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ORIGINAL ARTICLES.

IMMEDIATE CAPSULOTOMY FOLLOWING THE REMOVAL OF CATARACT.*

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All ophthalmic surgeons endeavor to obtain perfect vision after the removal of a cataract. On account of its prevalence, the loss of one of the most valued of the senses, and the restoration to vision by a bloodless and painless operation, have concurred to render this operation an object of the highest attention to surgeons; and the progress of improvement in the operation has been commensurate with the advances made in surgery elsewhere in the economy. Unfortunately, with all our skill and knowledge, success does not always follow the removal of an opaque lens. The many contingencies incident to the healing of the wound, the distortion of the cornea, the subsequent change in the media caused by iritis, or a thickening of the posterior capsule—one or all of these factors play a very important role in the subsequent restoration to vision.

The opaque lens, with its capsule, obstructs the vision, causing blindness of the patient. To remove this obstruction requires considerable dexterity; to restore vision, absolute cleanliness and most careful after-treatment. The most disheartening factor in a cataract operation is that sooner or later the posterior capsule thickens, and again dimness of vision follows; the lessening of the sight is not so great as it was before the removal of the lens, but still the patient is debarred the comfort of reading, writing, or attending to

business matters in which it is necessary to have perfect vision. It is to prevent this latter change that I advocate the splitting or parting of the posterior capsule at the time of the primal operation.

Having had the opportunity of following many operators, good, bad, and indifferent, and noting the after results, I frequently saw excellent vision follow bungling manipulation. The surgeons did not possess that delicate sense of touch so essential in making the corneal incision, snipping the iris, lacerating the anterior capsule, and delivering the lens. They lost courage, or their hand became so tremulous after they had ruptured the capsule, that the operation would have been a failure had they not taken a lens scoop in hand, entered the eye, and fished out the cataract and its capsule, with always more or less loss of vitreous. With very great care in the after-treatment, many of these patients would recover, and in the majority of cases which did recover, no capsule interfered with their visual acuity. It was witnessing such operation that led me to think that a parallel process, carried out, however, on more delicate operative lines, at the time of the primary operation, would still lessen the dangers that such harsh measures would be sure to excite.

The ancient method of removing cataracts from the direct line of vision was by *couching*; that is, passing a delicate needle through the sclerotic coat on the temporal side of the eyeball, posterior to the ciliary bodies; pressing it forward and into the

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crystalline lens. Then, by a backward sweep of the point of the needle, lens and capsule were torn from their position and deposited down and out in the vitreous chamber. Celsus, the celebrated Roman physician, who lived at or about the commencement of the Christian era, describes, and is generally esteemed the father of this operation. It was not very satisfactory in its results, according to the data obtainable from the earlier writers. Fabricius, who flourished in 1600, speaks with great despondency of this operation; later on, Hiester, 1711, says: "Though the operation is easy to be performed the success is so very precarious, that amongst a great number of persons couched by the most distinguished oculists, very few met with the desired results; and upon the vast number of patients upon whom the celebrated itinerant, Taylor, operated, not one in a hundred recovered his sight." He further says, "that in several different places he saw many miserable objects in tormenting pain, arising from inflammation consequent upon the operation, and that of those who regained their vision, there was scarcely one in ten who did not sooner or later lose it again." For eighteen hundred years this puncturing of the eyeball, with its most deplorable results, was the only method held out to the blind. It was the outgrowth of an accident which gave birth to the rival plan of extracting the opaque lens through an incision of the transparent cornea. It was the failure to remove a cataract which had escaped into the anterior chamber by couching, that led M. Mery to recommend, in the year 1707, the practice of extraction in all other cases of this disease. It was left, however, for Daviel, the celebrated surgeon of Paris, 1745, to bring forward this method as one infinitely less dangerous than couching. From that day to this the incision is made through the cornea, or along its margin, and the percentages of loss is to-day what the gain of vision was one hundred and fifty years ago.

PRELIMINARY TREATMENT ESSENTIAL IN CATARACT OPERATIONS.

I deem it of the greatest importance to interrogate all cataract patients presenting themselves for an operation, as to their general habits and family history, and to make a careful examination of the urine, restricting meat diet and increasing a veg-

etable one; while last but not least, placing the patient, one week before the operation on the mixed treatment, also paying particular attention to bathing both eyes with a boracic solution containing sulpho-carbolate of zinc; examining the eyelashes and particularly the nasal cavities. If any catarrhal affections are found in these cavities, it is of paramount importance that they receive the proper treatment before an operation is performed. The day before the operation, the patient is given a warm bath and a saline purgative, kept in bed, and his face washed with castile soap and water, then washing the skin around the eye to be operated upon with ether, following this again with a 1:5000 solution of corrosive sublimate, after a German method (Schweigger).

The reason I call attention to these minute details is that the patient may suffer from some defect which would not affect an eye in a comparatively healthy state, but might exercise an extremely pernicious influence on the eye after the irritability following the operation. The effect to be dreaded is inflammation, and therefore every measure calculated to prevent its occurrence must be taken. There are still a few ophthalmic surgeons who think it quite unnecessary to take these preliminary precautions, but, happily, the number is growing less year by year.

At the time of the operation, still greater precautions are taken; the patient's face, neck and mouth are thoroughly cleansed; clean underclothing, over which, and fitting close to the neck, a sterilized sheet is wrapped; head bandaged in a sterilized towel, and the eye irrigated with an aseptic fluid, as hot as the patient can bear it. The instruments are also sterilized; all fluids, such as atropine and cocain, are sterilized in a Llewellyn flask. The operation is performed then in the usual manner.

After the delivery of the lens (cataract) and all cortical matter is washed out of the anterior chamber, I proceed with the rupturing of the posterior capsule—the subject of my paper. The instrument used is a gold enameled hook, made as delicately as is consistent with keeping its shape. It is of malleable steel, so that it may be bent to any angle which I find is convenient, especially when the eye of the patient lies deep in the orbit. The hook is passed into the anterior chamber,

and behind the lower pupillary margin of the iris, on its flat side. It is then rotated backwards, hooked into the capsule, drawn gently upwards to the mouth of the incision, rotated on its flat again, and then taken out of the chamber. By this means, the capsule is torn, and the vitreous presses forward between the rent. Very little or no vitreous shows at the mouth of the wound. If it does, I snip it off.

When the operation is performed after the simple method (without iridectomy) the same manipulation is carried on with but one exception; and that is, the line of incision is not so long. The ophthalmostat is removed, and the eyeball again irrigated with hydrostatic eye-douche, followed by dropping one drop of sterilized Atropia solution into the eye; the lids closed and thickly anointed with vaseline, which has been sterilized by boiling; over this, specially devised eye-pads, which have also been sterilized by heat, held in place by adhesive strips, which keep the bandages, securely fixed, permitting the patient to change his position in bed as often as desirable. In twenty-four hours the dressings are removed, and both eyes bathed with warm water, and irrigated with the sulpho-carbolate solution, another drop of Atropia applied, and similar eye-pads adjusted with as much care as at the primal operation; and so continued from day to day until the eye is out of danger.

Is this a new operation? Some of the older writers of fifty years ago, hint at the removal of the lens and its capsule, but they are not explicit enough to say that they did so. The only authority that I can find saying so positively, is Richard Middlemore, who on page 138, Vol. II, in his great work on "Diseases of the Eye," published in 1835, after speaking of the removal of the lens, when the pupil is not clear, on account of the thickening of the posterior capsule or the hyaloid membrane, says: "In every such instance, I have found it absolutely essential to the successful result of the case, to lacerate the posterior capsule and hyaloid membrane, and permit the escape of a portion of the vitreous humour." Coming nearer to our own day, I must say a few words about the distinguished surgeon who left his impress upon all who witnessed his wonderful skill as an operator. I have reference to the late Dr. Richard J. Levis, of this

city. I have had the opportunity of examining quite a number of patients, from whom cataracts were removed by this eminent surgeon. In nearly every instance the posterior capsule was evidently ruptured at the time of primal operation. Whether this was a constant practice of Dr. Levis' I am unable to say, but I am sure he realized the importance of removing the posterior capsule at the time of the original operation. Pagenstecher, of Wiesbaden, is also an advocate of removing the lens and its capsule at one sitting. Hasner, another German ophthalmologist, is an advocate of this radical operation. It has recently come to me indirectly, that Dr. Knapp, of New York, is also lacerating the posterior capsule at the first operation.

Is the operation always successful? Laceration of the capsule alone does not prevent the hyaloid membrane from becoming slightly translucent. When this takes place, we may follow with a needle operation, and not provoke cyclitis by trying to tear a tough, inelastic tissue.

I have been in the habit of performing this operation in alternating cases, for ten years. In those patients upon whom the operation was performed, I had to repeat a needle or capsulotomy (scissors) in about fifteen per cent. of the cases. Where it was not performed, in about seventy-five per cent. In the fifteen per cent. of the cases where it did not succeed, I can only attribute it to a very thick posterior capsule, the vitreous receding after closing of the eye-ball, and thereby not keeping the capsule separated, but practically closing again. My experience has led me to believe that there is less danger of inflammation of the eye-ball in immediate capsulotomy, than in a subsequent operation.

The elder operators recognized the gravity of puncturing an eye-ball with a needle, and hailed with delight the improved method which completely revolutionized statistics. My own experience is fast leading me to adopt the cutting through the cornea with keratome and the incision of the capsule with a De Wecker's scissors, disregarding the needle altogether. With the preliminary treatment, and with the aseptic methods now employed, success is almost always assured; whilst with the treacherous needle, almost every surgeon has had reason to regret this *modus operandi* in more ways than one.

BATHING, SWIMMING, AND DIVING AS CAUSES OF AURAL DISEASE.

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Before entering into an account of the manner in which the ears of bathers are affected, it will be of interest to consider the construction of the ear in animals living a portion of the time submerged in water. A large number of marine quadrupeds may be included in this class, such as the crocodile, seal, hippopotamus and the like. These animals can remain under water a long time before coming to the surface for the purpose of breathing, and it is found that the construction of their ears is such that no damage occurs to the organ from frequent excursions under the water, which is colder than the surrounding atmosphere and would be irritating to delicate structures.

Some of the lower orders of marine life living exclusively in the water, have no special auditory nerve but receive sound impressions by means of shock imparted to the body.

The tympanic membrane and other parts necessary to sound transmission in mammalia are said to be absent in snakes and many saurians, though lizards and frogs have an exposed drum-head. Moles are said to have a closed external auditory meatus which excludes earth in burrowing; and the camel when exposed to the sand-laden simoon of the desert has the ability to contract the nostrils at will.

Swimming and diving in cold water is a frequent cause of disease of the external auditory canal and external surface of the membrana tympani, as also of the middle ear, though bathing in river or sea water is, when wisely and properly regulated, both healthful and pleasant. The evils attending bathing and swimming in cold water are the entrance of this cold fluid, not only into the external meatus, but as far as the membrana tympani, causing inflammation of the lower portion of the auditory canal, and of the anterior surface of the tympanic membrane. A still greater evil is from sudden deglutition, *i.e.* making the effort to swallow during diving or swimming, by which—the mouth, nose and pharynx being filled with cold water, and the mouths of the Eustachian tubes open—a portion of water passes into the

middle ear. This result rarely occurs in expert swimmers and divers, but is most common in beginners, who from cold, or the shock of the contact with the water suddenly breathe or swallow in a sobbing manner. We have, however, known it to occur in old and experienced swimmers while plunging head foremost, termed a "header," owing to the intense coldness of the water the act of deglutition being involuntary. Bathers in the surf are liable when off their guard to be struck by the waves upon the ear with much violence, especially in boisterous weather at full tide. Cold salt water may thus enter the external auditory canal with sufficient momentum to rupture the drum-head, especially in persons having a large, freely open canal. Swimming or floating upon the back, especially the latter, when the ears are submerged, or diving and swimming beneath the surface, often exposes the ears very much to the entrance of the water.

The lovers of sea-bathing will learn with much interest the result of a series of observations on the temperature of the sea, which were completed some time since by the Scottish Meteorological Society. The observations were made every day during a period of four years and nine months, and the result was to confirm the impression that the changes of atmospheric temperature influence the sea but slowly. The variations in the warmth of the sea-water occur within a range one-third less than that of the air; and the mean temperature of the sea is found to be warmer than that of the atmosphere in seven months out of the twelve. The summer warmth penetrates the sea very gradually, and is more gradually given off. January is the coldest month, but the sea-water is coldest in March. July is the hottest month but the sea-water attains its maximum warmth toward the end of August. From that time the sea becomes warmer than the air, and cools so much slower than the weather that in November the average warmth of the water is six degrees, and in December seven degrees, higher than that of the atmosphere. The balance is reached at the end of March,

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and then for the next five months the air is warmer than the water.

These figures, which result from careful observations made at Peterhead, justify the custom of extending sea bathing late into the autumn. Sea bathing should, in fact, begin late and may safely end late. It is more dangerous in the warm days of early summer than in the chilly days even of the late autumn. The sea is as warm at the end of October as it is in the second week of June, and the period between these two dates is the healthy bathing season for those who are strong enough to begin early and leave off late.

If the water is not removed by placing the head to one side, and drawing the external ear forcibly outwards, shaking the head at the same time and opening the mouth, also striking the external ear with the palm of the hand, it is apt to cause inflammation as the water decomposes, followed by perforation of the membrana tympani; or, the inflammation with the formation of pus, if neglected, may pass inward to the middle ear, cochlea and labyrinth, and implicating the brain, may terminate in death.

It is a well recognized maxim among those who devote special attention to diseases of the ear, that no cold fluid should be allowed to enter even the external auditory canal; still this important fact is not sufficiently recognized by the profession at large. The entrance of warm water into the ear is less objectionable, but even this is not quite free from danger, and has its disadvantages; and the water should in all cases contain a few grains of saline ingredient, like borax, soda, or common salt, a teaspoonful to the pint, when employed in washing out the ear. The symptoms of water in the middle ear are, in the first stage, an uncomfortable sensation followed by earache or pain, which after a time, if neglected, becomes agonizing, and is accompanied with great tenderness behind the auricle. In proof that water in the ear is injurious and causes deafness, we might cite a number of instances. It is a well known fact that dogs which are thrown into the water become deaf.

Many cases of this form of disease in its chronic stage, come under treatment during all seasons, but acute cases from swimming and diving, occur during the spring and summer months, chiefly in

boys from eight to sixteen years of age; a much smaller number occurring in the fall and winter. If the acute form be promptly treated, entire recovery takes place; but should the case not be seen until after the chill, it is always followed by a discharge of shorter or longer duration.

The following is a summary of the aural diseases and complications of existing diseases for which patients applied for treatment:*

Acute purulent otitis media; chronic purulent otitis media (from repeated exposure in bathing); acute catarrhal otitis media; subacute catarrhal otitis media; acute exacerbation of existing chronic purulent otitis media; otitis externa diffusa; otitis externa circumscripta; otitis externa exudativa; myringitis (either independently or in connection with inflammation of the external auditory canal); impaction of cerumen; otalgia due to exposure, etc.; aggravation of symptoms arising from chronic catarrhal inflammation by abuse of sea bathing (bathing frequently and remaining in the water too long).

In cases not recognized, the symptoms of violent headache, furious delirium and coma, give the physician the impression that disease of the brain is present, and the cases thus improperly treated sometimes terminate in death. The morbid condition in the first stage consists in acute inflammation of the extremely delicate mucous membrane lining the middle ear. The inflammation is followed by effusion of fluid, and after twenty-four hours by the formation of pus. It is in every instance attended by fever, with swelling and inflammation of the naso-pharyngeal space and great pain. If this fluid or pus be removed by incision into the membrana tympani, followed by the use of the air douche and injections of hot antiseptic wash, the patient recovers and the ear is saved. The patient is apt to remain deaf for several weeks, and the use of Politzer's air douche is necessary to keep the Eustachian tube open; the local application of tincture of iodine brushed over the mastoid facilitates the removal of the inflammatory thickening. To diminish the discharge of pus, should it continue, we may employ a powder of boric acid, blown into the meatus before it is washed out,

* Sexton—"The Ear and its Diseases."

and reapplied twice a day until the discharge shall have ceased and the perforation become closed.

In Australia and India, where they have a very hot climate and most of the towns are on the sea coast, the people bathe very frequently, some even three times daily, from June to October. During these months it has been noticed (Dr. Kenny) that the number of patients suffering from ear troubles has been considerably augmented. They bathe in large enclosures for fear of the sharks, and these baths have a depth of water from twelve to sixteen feet. At these great depths the bathers are constantly diving, and added to the irritation of saline water in the auditory meatus, there is also the great increase of pressure to which the membrana tympani is subjected.

Dr. Macnaughton Jones has noticed the occurrence of exostosis within the meatus to persons very fond of sea bathing. The ears, when tender or diseased, in ladies should be protected in bathing by an oil silk cap, while gentlemen should place a piece of wool in the ear, or some form of protection which can be removed as soon as the bathing is over.

Russian and Turkish Baths.—Acute inflammation of the middle ear, etc., is liable sometimes to occur after the use of these baths, which render the patient extremely susceptible to cold and consequent catarrh of the upper air-passages.

Sexton reports four cases of aural disease resulting from long continued indulgence in the Turkish bath. Two of these patients had chronic purulent otitis media, and one chronic catarrh of the middle ear, while one patient was suffering from acute inflammation of the auditory canal.

Six cases of acute purulent inflammation of the middle ear, resulting from the effects of getting water in the ears or from the susceptibility induced by baths of various kinds, were recorded: A shower bath in 1 case; hot water baths in 2 cases; hydrant water falling in the ear in 1 case; exposure after ordinary bath in 1 case; bathing when overheated in 1 case.

One patient, a male 40 years of age, who was suffering from chronic catarrh of the middle ear, attributed a marked increase of tinnitus aurium to taking a cold bath.

THE INJURIOUS INFLUENCE OF WATER INTRODUCED INTO THE EAR BY THE NASAL DOUCHE OR SNUFFING UP COLD WATER.

We have explained the injury which results from the introduction of water into the auditory canal, also the serious disturbance produced by the same when passing into the Eustachian tube by very sudden efforts at swallowing, now the same results will follow the improper use of what is known as the nasal douche or in snuffing up cold water or solutions of medicinal substances. The first great point is to remember that the fluids should not be cold; the second, is that the head should be kept level and not thrown very far back; third, individuals using this method of cleansing the throat and back of the nose should not expose themselves to the open air for some time after using either of these methods. It is much better to use the steam or spray form of apparatus as less risk to the ears, and the result in a medical view will be as good, if not better, as cleansing agents.

The same results will occur from the post nasal syringe when improperly employed.

COLD WATER TO THE SCALP AS A CAUSE OF EAR DISEASE.

The present fashion in young boys and even men in cutting the hair close to the scalp, both in summer and winter, is a cause of disease of the ear. It is a well-recognized fact that we hear with the skin of the scalp and the bones of the head, and irritation by dampening the skin impairs the hearing, and when cold water is applied too freely it will produce coryza and earache. Again, young girls saturate their hair in bathing and then allow the air to dry it. Bathing caps should be always used under such circumstances. The hair is a great protection from cold, and during the winter should be used to protect the scalp and throat. The new form of clipper by which the hair is cropped very close is a cause of earache, likely to follow inflammation of the middle ear, especially if the person is afterward placed in a car or carriage or cab, and the wind allowed full play on the part.

COMMUNICATIONS.

APPENDICITIS FROM A MEDICAL STANDPOINT.

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The unfinished report of Dr. Cartledge on the classification of appendicitis, which was interrupted at our last meeting, and the exhibition of specimens of some late operations, suggested some comments on the subject from a medical standpoint. It was, therefore, made the special order for this meeting, and as I feel no more important question is agitating the public expectancy both here and abroad than this, I invoke by this method the local sentiment favorable or otherwise as to its advisability, and the character of cases deserving its application.

In this, as in many other of those heroic operations that enkindle the enthusiasm of the original promoters, and startle the laity with the wonders of science that thrills even the initiated, snatching from death the innocent victim, and restoring to health the misanthropic cripple, it certainly seems inexpedient for the unsurgical brother to dampen the ardor or quench the fire that illumines such desolate pathways. But, on the other hand, as license runs wild with its sensuous victories, and culprits stalk where angels fear to tread, the history of all these grand successes is blotted frequently by unrestrained excesses and the brilliant progress of the art destroyed by the unwary and the charlatan; and it does become at times the duty of the peaceful practitioner, standing apart as it were from the conflict between the knife and dissolution, to stay the hand grown riotous by acclamations.

Not that I expect to say anything new on the subject, worn threadbare possibly already, but simply to bring to a more vivid experience its faults and triumphs, as demonstrated at home. The unalterable fact obtains, however, that a sentiment is fast gaining assertion amongst the medical members of the brotherhood, who formerly after diagnosis relinquished without question their subjects to the knife, and contrawise amongst many of the adroit surgeons themselves there is already a disposition to eliminate many of their former operable cases.

Only a few years ago it became an open boast that laparotomy was, in skillful hands, a decidedly safe operation, so entirely harmless that it took rank among exploratory procedures, and it was growing as common to cut open the belly to elicit or confirm a diagnosis as to perform many of the minor operations; so much so that in many instances life was sacrificed in the useless search for supposed disease in healthy organs. Nor do I wish to affirm here that the quest was uncalled for, nor to blight the fame achieved in some of those undertakings, but I *do* assume that in many instances the gravest concern must follow imprudent proceedings.

The most serious obstacle to the fullest enlightenment naturally occurs from that want of frankness in the ranks of the profession itself, which interposes an almost insuperable barrier to a quick and decided solution of its utility; and for many reasons, but primarily because the experimentation which naturally opens so many new fields of conquest in surgical enterprise, only proves their availability by continuous research, and they traverse many tortuous courses before the danger signal calls a halt. Secondly, I presume the implied acquiescence to doubtful results, and the frequently unquestioned exhibition of specimens that do not fully bear out the alarming aspect the operator would have us affirm.

I have no doubt that many lacerated appendices could trace their origin to the inevitable rudeness that attended their separation, and seem to give credence to an urgency that calmer retrospection would deny. Of course the gravity of the responsibility where fatal results attend these operations, militates strongly toward the defense of measures attended by such fateful consequences, and whether the operation were wise or incompetent, a fellow feeling for the author would bias an untoward criticism of his work.

As I intend this introduction to the discussion of the evening as a prelude of more statistical facts in its elaboration, I

shall not enter fully into the etiology (which is somewhat obscure), nor to the technique (which belongs properly to the surgeon), nor the diagnosis (which is the property of both), nor the pathology (which is the rock that divides the limpid stream of life, and the election of either channel after its passage, whether it be medical or surgical, decides in a large degree the fate of the eventful voyage). Of course the supreme comprehension of them all merges into the general field of treatment, when the battle-gauge is given and upon which depends the weal or woe of the subject.

To those painstaking, erudite, thoughtful, conscientious surgeons who bring to their task, in these monumental trials, the unimpeachable strength of purpose that wavers before no disaster, nor incriminates their courage, be the results what they may, always remembering a human life is in the balance and at the mercy of their prowess, I wish to bow in humble gratitude and sublime devoir. If there is any lofty pinnacle to which ambition towers and upon whose crest reposes its godliest hero, I believe the crown is theirs. In silent chamber and with bated breath the hovering circle waits his wondrous coming, and the canticle of joy or the deep-toned requiem, his departure.

Is it wonderful, then, that we should pause in contemplating the risks and adventures that environ every step, or stop in this debatable territory? In this connection it is interesting to note that Talamon of Paris, Guttman of Berlin, and Treves of London, affirm that from 85 to 90 per cent. of patients suffering from appendicitis recover spontaneously without the use of the knife, and Maurin and Hektoen through many hundred autopsies demonstrate the fact that from 16 to 30 per cent. of peri-appendicular adhesions, some even where perforation itself had occurred, were found with no antecedent history that tokened their existence. With this fact staring us in the face it becomes a moot question, whether the late day recognition that appendicitis is the cause of 95 per cent. of diseases invading this territory, mostly in the hands of some, demanding operation for relief, has been a blessing or a curse to humanity.

As regards its etiology, much commendation can be taken from the assurance that fæces, calcium salts, etc., are the

concretions met with, rarely seeds or foreign bodies, so that we can return with renewed enjoyment to the small fruits of early life when we devoured baskets full without consequences.

The diagnosis, coupled with its subsequent prognosis, is, I take it, the foundation stone of the whole fabric, mysterious as it must be in an affection which may be acute or chronic, continuous or relapsing, with great variation of often indefinite symptoms comparable to typhoid, peritonitis, strangulation, typhilitis and others. Pain, the most prominent of all, is frequently referable to other regions, though in males (and I have not seen it mentioned) it is mostly located in the testes, and is of great intensity. It may be absent, although the most prominent symptom. The temperature is vexing; tympanites and vomiting are variable in their appearance and conflicting; acute indigestion and nephritic colic are most confounding; the pelvic derangements lend no small assistance to the general confusion; to the practiced eye the semishock in the acute, and the peculiar malaise in the chronic cases, accentuate its intuition.

As I said before, the condition of the viscera and appendix furnish food for controversy, even after removal.

As regards treatment, whether it shall be medical or surgical, brings the issue for yourselves to decide.

There is no question that the literature of this subject has changed rapidly during the past few years to more conservatism in the use of the knife, and personally and from individual experience I have not found the relief from appendisectomy that is claimed or I had expected. Without citation of individual cases, the results have been far from gratifying, nor do I believe the death rate as light as reports would make us believe.

I present here an extract from one of the daily journals of last week, which probably escaped the notice of even the majority of the profession, bearing mute but inglorious witness to the prevalence of its abuse:

"VICTIM OF EXPERIMENT.

Death of Norman Munro, the New York publisher. Submitted to an operation for appendicitis when it was unnecessary.

"NEW YORK, February 24.

"Norman Munro, the yachtsman and publisher, died at 6.15 o'clock to-night, at the Hoffman House. The cause of death was heart failure.

"Mr. Munro had undergone an operation for appendicitis, but it was afterward found that the patient was not suffering from the disease, and that the operation was not necessary.

"Henry, Mr. Munro's eleven-year-old son, who attended a private school at Dobbs' Ferry, had his vermiform appendix removed by Dr. Abbe on Sunday last. The boy had complained of a pain in his right side immediately after coasting. He is convalescent now.

"HAD THE SYMPTOMS.

"Mr. Munro complained of a soreness in the right side early in the week, and suspected that he had appendicitis. Under ordinary circumstances, he would not have given the matter much thought, but his symptoms being similar to those of his son led him to believe that he was suffering from the same disease. Mr. Munro became interested in the subject of appendicitis, and decided to have the appendix removed. The patient was put under the

influence of ether on Friday and the operation was performed.

"No foreign substance was found in the appendix of the parent or in that of the son. There was *only a gangrenous inflammation of the appendix*.* Mr. Munro recovered from the effects of the ether and conversed with his physicians half an hour after the operation.

"He seemed confident that he would pull through just as his son had done. During the night and early morning his condition grew rapidly worse. At two o'clock in the afternoon Dr. Abbe said the end was looked for any moment. His family was present when he died."

A "Victim of Experiment" was the flashing headline in large type that chronicled the catastrophe, although the operation, it appears, was performed by Dr. Abbe, one of the leading men in our ranks.

The discussion of this interesting subject cannot fail of the most salutary effect at all events, and for the sake of that great medical enlightenment that is making our age more brilliant and progressive than any of its predecessors, I hope it will continue until the veil is lifted from its present obscurity, and the refulgence of its promise becomes brighter for the ordeal it has endured.

A CASE OF MULTIPLE NEURITIS (ALCOHOLIC).

HERMAN D. MARCUS, M. D.,* PHILADELPHIA.

The following case is interesting, owing to the markedly low temperature and its duration for 132 hours.

L. N., female, aged 34 years, was brought to the Philadelphia Hospital on December 31, 1892, in an entirely helpless condition. Her condition was as follows:

Mental State: Somewhat variable, seems at times rational, again wandering, mistaking those around her for former friends. Occasionally a mild muttering, delirium and hallucinations. At times believes herself at home, not recognizing her surroundings, although she has been in hospitals before.

Motor Condition: Complete paralysis of both legs, with the exception of being

able to move left thigh from pelvis, flexing it slightly. Limbs remain in whatever position placed. No foot-drop. Great toe slightly depressed, other toes slightly curved. Has marked double hand-drop; also partial paralysis above elbow, but is able to partially elevate the arms. No facial or ocular paralysis.

Sensory Condition: Lower extremities are everywhere anæsthetic, showing difference in degree, mostly marked below the knees and decreasing on ascending, continuing to ensiform cartilage. Partial anæsthesia of upper extremities, decreasing from distal to proximal ends. Retardation of sensory condition in areas of anæsthesia. Handling of nerve trunks in lower extremities causes severe pain. Squeezing of feet, moving limbs and compressing muscles, or very deep pressure

* Italics are ours. Comment is unnecessary.—Ed.

* Late Resident Physician at the Philadelphia Hospital.

causes severe pain. Patient is in constant fear of being touched. The hyperæsthesia on deep pressure is also imminent in upper extremities.

Vaso-motor and Trophic Condition: Dark, softened areas on heels. On buttocks and in lumbar region skin shows some change, and in one place the skin is broken, resembling a bed-sore. Left knee is apparently increased in size, an apparently acute atrophy. Has involuntary evacuations of bowels and yellowish green vaginal discharge.

Treatment: Following treatment was prescribed by Dr. Mills, the visiting physician: Bathe lower limbs once daily, for 10 minutes with hot water (115°), followed by inunction in legs of

R Atropine sulph. gr. 1-6
Ung. hydrarg. 5v.
Lanolin. 3iii.

M. Use $\frac{3}{4}$ twice daily.

R Tr. nucis vom. mv.
Tr. digitalis. mx.

Every 4 hours.

R Sodii salicyl. gr. x.
Sodii iodid. gr. v.
Sodii boom. gr. v.
Aque. f3i.

Every 4 hours.

Wash eyes with Boracic acid.

Vaginal douche (bichloride mercury 1-5000) once daily followed by hot water; sand bags to arms and legs.

Two days after admission, January 21, 1883, following was noted. Almost constant delirium—mind not as clear to-day as on 31st ult. Rambles almost continually, but by a strong effort her attention can be held and she can be made to respond sensibly to some questions. Complaints of pain when her limbs are moved. Anæsthesia of legs continue, paralysis of legs unchanged. Paralysis of upper extremities increased somewhat, having now no control over movements of upper arm. Her feet tend to fall into crucial position, probably due to a paralysis which is merely below knees and less marked above. Her tongue is dry and brown. No urine passed from this morning until 2 P. M. Treatment continued and ordered catheterized every four hours.

January 3d. Pulse between 115 and 120, weak and compressible; temperature about 99°; respiration shallow and hurried (about 30); still incoherent, but her mind is clearing up. On examination paralysis of extremities has increased since yesterday, so that now she is barely able to

make a slight movement of elevation or adduction. Some slight increase in sensibility in both arms; knee and muscle jerks abolished.

From this on her condition became variable, at times rallying then again relapsing into her former state.

Strychina sulph. gr. $\frac{1}{15}$, was prescribed three times daily on the 9th, and to this was added whiskey 3iii, milk f3iii every half hour, in divided doses. The sodium mixture was discontinued. On the 12th, her temperature became subnormal, 96.6°, and from then on sank gradually until the 16th, it reached 91.2° at 7 P. M., rising to 92° at 11 P. M., and remaining at this point until her death on the 17th, at 8.30 A. M.

The temperature was taken both in the mouth and rectum, with a Hick's thermometer. This thermometer was afterwards tested and was found positively correct.

The Awakening Effect of Cocaine.

A few days ago a patient who had toothache, wishing to stop it immediately, secured nine grains of cocaine in solution, and took it into his mouth a little at a time, holding it until the accumulation of saliva became so abundant that he had to spit it out. He began using the cocaine in this manner at 5 P. M., and did not cease till 10.22 P. M., same evening. As it was then bedtime, he thought he would make sleep certain by taking 20 grains of chloral. Immediately after taking the latter drug, he took into his mouth some more cocaine and went to bed. He "swashed" the cocaine solution about in his mouth a while, then spat it out, turned on his side, and tried to go to sleep. Sleep, however, did not come; on the contrary, he did not even become drowsy. Having lain awake till midnight, and not feeling sleepy at that hour, he took, as nearly as he could tell, about *one teaspoonful* of laudanum. He went to bed again, and remained awake till three o'clock. Sleep lasted only four hours. Following this was headache.

I have often had my attention called to the fact that cocaine will keep patients awake at night when the drug is administered late in the day, but I did not know that 20 grains of chloral and a teaspoonful of laudanum would not overcome "cocaine wakefulness."—*Medical Record*.

TRANSLATIONS.

THERAPEUTICAL SUGGESTIONS FROM FOREIGN JOURNALS.*

A PILL FOR ANÆMIA.

Prof. Edlefsen (*La Semaine Médicale*, No. 24, 1894) recommends the following pill in anæmia:

℞ Iron reduced by Hydrogen,.....
Powdered Camphor,..... $\frac{aa}{6}$ | o (3jss).
Extr. Gentian,..... $\frac{5}{1}$ | o (3j i 4).
Mucilage Gum Arabic,..... $\frac{q}{s}$.
Sufficient for ninety pills. Two to three pills three times a day.

He has found this formula of value both in anæmia and in chlorosis, especially when they are accompanied by cardiac disturbances as weakness and irregularity of the pulse.

ECHINOCOCCUS CYSTS.

Prof. Bacelli (*Medicinische Neuigkeiten*, No. 15, 1894) treats echinococcus cysts by injection of a solution of sublimate. If the parasite is situated in the liver he punctures with a well sterilized trocar of a diameter of two and a half mms. the cyst at its highest point, and withdraws a moderate quantity of the fluid, following this with an injection of about twenty grams of a 1-per-cent. solution of sublimate. The tube is withdrawn and an antiseptic bandage applied. In five days the dressing is removed. The parasite is then destroyed and the subjective and objective symptoms gradually retrogress.

SENECIO IN FUNCTIONAL AMENORRHEA.

Dr. Murrel (*Hospitals-Tidende* No. 15, 1894) has experimented with senecio as a remedy in functional amenorrhœa on account of its being employed in England as a domestic remedy in this affection and with good results. He used a 10-per-cent. tincture of this plant in doses of an ounce four times a day. In amenorrhœa, due to general anæmia, it was inactive.

MIGRAINE.

Dr. Freudenberg (*La Semaine Médicale*, No. 16, 1894) advises the use of the following formula in migraine:

*In charge of the Translator, F. H. Pritchard, A. M., M.D.

℞ Mur. Morphine,.....0 | 01 (gr. i-6).
Salicylate Soda,.....0 | 25 (gr. iv).
Phenacetine,.....0 | 25 (gr. iv).
Sufficient for one powder. One or two according to circumstances.

Dr. Tchetius (*ibid.*) recommends the following:

℞ Saccharine,.....0 | 01 (gr. i-6).
Mur. Quinine,.....0 | 05 (gr. j).
Salicylate Soda,.....0 | 15 (gr. i ss).
Phenacetine,.....3 | 0 (gr. xlv).
Sufficient for ten capsules. One at a dose.

ECZEMA IN CHILDREN.

Dr. Marfan (*Hospitals-Tidende*, No. 15, 1894) distinguishes two forms of eczema in children: a seborrhœic, and a dry and patchy form. In the seborrhœic variety, in fat children, he reduces the amount of food and administers calomel, or removes the crusts and applies the following salve:

℞ Precipitated Sulphur,.....1 | o (grs. xv).
Oxide Zinc,.....4 | o (3j).
Lanoline,.....
Vaseline,.....15 | o (3iv).

In the other form he applies locally:

℞ Salicylic Acid,.....0 | 05-10 (grs. j-jss).
Starch,
Oxide Zinc,..... $\frac{aa}{40}$ | (3j).
Lanoline,
Vaseline,..... $\frac{aa}{15}$ | 0 (3vj).

EARACHE.

In the (*Progrès Médical*, No. 16, 1894) the following is praised in earache of inflammatory origin:

℞ Powdered Menthol,.....1 | 25 (grs. xix).
Camphor,.....1 | 25 (grs. xix).
Vaseline,.....24 | 0 (5vj).

Introduce a little into the ear several times a day.

A CASE OF SORE THROAT FROM COPAIVA.

Dr. Mendel (*Le Bulletin Médical*, No. 24, 1894) had under observation a young man of twenty-two years, who, for gonorrhœa, took for several days nine capsules of copaiva a day, and then broke out with a pronounced erythematous copaiva exanthem of the ordinary appearance, and with the following throat symptoms: the soft palate, uvula, tonsils and the anterior portion of the faucial arch were very red and œdematous. The œdema of the uvula was so great that it was increased to double its

size. The whole of the hyperemic portion was covered with numerous miliary, deep-red and vesicular prominences. This state persisted for three days, when it disappeared with the erythema.

FALLING OF THE HAIR AND RINGWORM.

Dr. Brocq (*Progrès Medical*, No. 16, 1894) recommends the following, both in falling of the hair and ringworm:

R	Carbolic Acid,	
	Chloral,	
	Tinct. Iodine.....	ââ 100 o (3ij 3j).

Apply once a week with a brush. Three to four times for ringworm.

CHOLERIFORM DIARRHŒA IN CHILDREN.

Dr. Braithwaite (*La Semaine Médicale*, No. 24, 1894) has had good results in choleriform diarrhœa in children with the following:

R	Salicylate Soda	
	Sulphate Iron.....	ââ o 60 (grs. ix.).
	Neutral Pure Glycerine..	10 o 3 (jss).
	Water.....	40 o 3 (jss).

A teaspoonful four times a day.

LOCAL ANÆSTHESIA IN EXTRACTION OF TEETH.

Dr. C. Karacatsanis (*La Semaine Médicale*, No. 24, 1894) extracts teeth without pain by first applying a strong solution of tufts of absorbent cotton to each side of the tooth, and as soon as anæsthesia is complete, the gum is separated from the tooth by means of a bistoury, and fresh pledgets of cotton are again placed into these cavities. The patient should be cautioned not to swallow his saliva, as it is more or less saturated with cocaine. Then a little of the following mixture is sprayed onto the gum:

R	Chloroform	25 o (3vj).
	Ether	40 o 3j 4j).
	Menthol	3 o (grs. xiv).
	Mur. Cocaine	3 o (grs. xiv).
	Essence Peppermint	ââ. 1 o (grs. xv).

The tooth is then extracted. There will be no pain with all forms of toothache, except with alveolo-dental periostitis, it is where it is impossible to subdue the pain entirely.

(This procedure would seem rather bothersome and slow. I employ a hypodermic syringe, and inject at the base of each root of the tooth to be pulled, a few drops of a 2-4 per cent. solution of cocaine

with strong carbolic acid added, massage the gum for a minute on each side, and after cutting around the root, extract. In order to avoid pain the solution must be deeply injected around each root until the gum turns white. There is some danger of dangerous effects from the cocaine in such vascular tissues as the gums even with a 1-2 per cent. solution; excitement, slight delirium, paleness, faintness, coldness of the hands and feet and nervous twitchings, or even chilly sensations. I have had as many cases of untoward effects from weak as with stronger solutions. Carbolic acid acts as a preservative for the solution, and aids the action of the cocaine as has been noticed by various observers, as Gluck, Van, etc. Atropine has been proposed as an efficient antidote to be added to the solution, but I have found it of very little or no service. The best antidotes are those vaso-dilators and cardiac stimulants as which act rapidly as nitro-glycerine and amyl nitrite. With the latter I have had no experience, but the former I can heartily recommend as worthy of confidence. I have employed it both with the solution to be injected and apart. It acts satisfactorily and at once, but only little is to be added to the injected solution, or it will spoil the action of the cocaine, much of which influence as an anæsthetic is due to its vaso-constrictive properties. I employ now a five-per cent. solution of the cocaine, add to this watery preparation, eight drops of strong carbolic acid and five drops of a one-per cent. solution of nitro-glycerine. I never have observed any disagreeable effects from the use of this, though without the nitro-glycerine the same preparation will give rise to trouble. Cocaine is always to be employed with caution and respected decidedly, for no one knows when it will act diastereably).—*Trans.*

Ichthyol.

This drug is proving itself to be one of the most valuable in the materia medica. An ointment consisting of twenty-five per cent. of ichthyol and seventy-five per cent. of lanolin, is the very best remedy for erysipelas. Ichthyol is also useful in rheumatism, in the form of an ointment consisting of equal parts of lanolin and ichthyol.—*Modern Medicine.*

BACTERIOLOGICAL NOTES.

THE ACTION OF LIGHT UPON THE DIPHTHERIA BACILLUS.

Ledoux-Lebard (*Archives de Med. Experimentale*) gives the results of his experiments to determine whether the influence of diffused light is destructive to germs as well as the direct rays of the sun. The conclusions reached are as follows:

1. The action of diffused light does not prevent the development of cultures of the diphtheria germs. The direct rays of the sun arrests the development of the germs. Diffused light has no bactericide power on bacteria in neutralized bouillon, but it has a marked bactericide power on the diphtheria bacilli in distilled water.

2. Diffused light kills dry cultures of diphtheria spread in thin layers in less than two days (24 hours' exposure to the light.)

3. The direct rays of sun light acts in the same manner as the diffused rays, but with greater rapidity.

4. The bactericide power of light in relation to the diphtheria bacillus is due very largely to the most highly refracted rays of the spectrum. The less refracted rays of the spectrum have little or no effect.

5. Light by virtue of its bactericide power, sterilized in less than two days the diphtheria bacilli either moist or dry, and

hence is a prophylactic agent against diphtheria.

6. In diphtheritic membranes exposed to the light, many of the bacilli are reached only by the light after it has lost part of its intensity, and hence the bacteria retain their vitality and virulence much longer.

8. Light may be utilized in the disinfection of places contaminated by diphtheria.

[The results here reported are of considerable interest when the persistent nature of diphtheria is considered. There are well authenticated cases, where the disease has been contracted from rooms or clothing used by diphtheria patients, years after the disease. It has been noticed that in these cases the infected article has been kept away from the light, and if a room, it has been kept darkened. About two years ago, Dr. Sternberg brought out anew the importance of sunlight in disinfecting against Asiatic cholera. It is also well known that other bacteria are exceedingly susceptible to the influence of sunlight. These facts should be carefully considered by all physicians and the use of sunlight freely indulged in. It seems to be effective and its more extended use may render it a much more valuable prophylactic agent than it now is.—Ed.]

AN EPIDEMIC OF TYPHOID FEVER CAUSED BY MILK.

In the *Zeitschrift für Fleisch und Milchhygiene*, Jan., 1894, there is an interesting account of an epidemic of typhoid fever in which the source of infection is very clearly shown to have been in the milk supply. An epidemic of this disease broke out in the two prisons of Strasburg in 1880, after twenty years of freedom from the disease. All of the inmates attacked had consumed milk from a particular locality. Of those who had used this milk once or more, 17 per cent. were attacked with typhoid; while out of the three hundred other persons who did not use the milk not one was attacked with the disease. The milk was used in an

unsterilized condition, and when its use was stopped the epidemic came to an end.

[The continued and constantly increasing number of epidemics of typhoid fever traceable to the milk supply as the channel of infection, is a signal for more rigid inspection of dairies furnishing milk to cities and communities. The danger, as is well known, is largely confined to the contamination of the milk with water containing typhoid bacteria. This fact renders it of great importance that the sanitary conditions surrounding the dairy should be carefully inquired into, and in all cases where there is a possible chance of the water used in rinsing the milk pans,

pails, etc., being contaminated with the dejecta from typhoid patients, the milk should not be used, excepting the most careful methods of sterilization are employed. Milk is one of the best media for the multiplication of typhoid bacteria, and the fact that these bacteria produce

no visible change in the milk by which their presence can be detected renders it a most favorable channel for these bacteria to gain entrance to the system. Too much care cannot be exercised to keep milk from becoming contaminated with these bacteria.—Ed.]

THE RELATION OF THE BACILLUS OF TUBERCULOSIS IN FOWLS TO THE ONE OF TUBERCULOSIS OF MAN AND OTHER MAMMALS.

Mafucci (*Zeitschrift f. Hygiene*, 1892) has studied the tuberculosis of fowls, and arrives at the following conclusions in reference to its bacillus:

1. It does not produce tuberculosis in guinea-pigs, and seldom produces general tuberculosis in rabbits.

2. On the various culture media it grows with an appearance different from that of the bacillus of mammalian tuberculosis.

3. It grows at temperatures between 35° C. and 45° C., and it is destroyed at 70° C.

4. In cultures at 45° and 50° C., the bacillus grows in long, thick, branched forms.

5. The bacillus retains, even after two years, its vegetative and pathogenic powers.

6. The destruction of the bacilli produces a substance which is poisonous for guinea-pigs and less so for adult fowls.

7. The tubercle excited by the growth of the bacillus in fowls is destitute of giant cells.

The bacillus of mammalian tuberculosis differs from that of avian tuberculosis according to Mafucci, in the following respects:

1. It produces tuberculosis in guinea-pigs and rabbits, but not in fowls.

2. Its cultures differ in appearance from those of the avian bacillus.

3. It grows at a temperature between 30° and 40° C.

4. It is destroyed at a temperature of 65° C. for one hour.

5. At temperatures between 43° and 45° C., it does not change its form in the cultures.

6. At 45° C. it loses its vegetative power in a few days.

7. The old moist cultures, after a year, are with difficulty induced to grow on fresh culture media or in the animal body.

8. The destruction of the bacilli gives rise to a substance that is poisonous for guinea-pigs, and often also for adult fowls.

9. The mammalian tubercle generally possesses giant cells.

On these grounds Mafucci holds that the bacilli of these forms of tuberculosis belong to two varieties, but he is not sure of specific differences. He is not decided as to whether man can take tuberculosis from fowls.]

[It is of interest to add that the thermal death-point of the tubercle bacillus is much lower than that given by the author.—Ed.]

For Ringworm.

Iodine has been found to be one of the most effective agents for destroying the parasite upon which this disease depends. An excellent method of applying it is the following: Thoroughly cleanse the scalp with soap and water. Dry perfectly, then apply a solution of one part of pure iodine in thirty parts of flexible collodion. Renew the application each day for four days. At the end of fifteen days, remove the collodion, wash the scalp first with soap and water, then, after thoroughly removing the soap, wash with a hot solution of bichloride of mercury, 1-2500. After allowing the bichloride solution to remain in contact with the scalp for half an hour, wash with pure water, dry, and apply vaseline or zinc ointment. If necessary, repeat the application.—*Modern Medicine*.

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SATURDAY, JUNE 9, 1894.

EDITORIAL.

STYLE IN MEDICAL WRITING.

The responsibility of the editor of a medical journal is very great. It is his duty to promote the diffusion of medical knowledge, not only by his own writing, but by seeking from contributors articles that will be useful to this end, and by selecting from contemporary publications the most valuable papers, of which usually only abstracts are presented. The medical journal is a most important means of professional aid and education. It ought to help the practitioner in his daily work, and it ought to enlarge the sphere of his knowledge, and stimulate him to active thought.

But whatever information, advice and instruction are given, the manner of their presentation is of great importance. "The style is the man," it has been said, and certainly the style of a medical contribution has much to do with its ready reception. Dr. Samuel Johnson, in his memoir of the illustrious Boerhaave, wrote: "Nor was he unacquainted with the art of recommending truth by elegance, and embellishing

the philosopher with polite literature; he knew but a small part of mankind will sacrifice their pleasure to their improvement, and those authors who would find many readers, must endeavor to please while they instruct." Accepting this statement from a great essayist in regard to a great physician—a physician so famous in his day that a letter sent to him from India, having on it only his name and Europe, came into his hand with reasonable promptness—we trust that a brief consideration of style in medical writing may not be unacceptable, and may prove of some value.

When the physician purposes writing a paper, let him, so far as possible, understand his subject, be reasonably certain that what he writes will be useful to the profession, and let him select a proper title for his essay. Probably there are more frequent mistakes in the last matter than in any other, causing no end of worry and trouble to those who are studying a subject, or who are preparing an

index of medical literature. Every child has a right to his own name, and so the medical contribution ought to have a distinctive title. To call the paper "A Remarkable Case," or an "Extraordinary Case," is almost meaningless, and quite mischievous. A similar criticism may be made of many other designations—designations that do not designate—applied to articles too often found in medical journals. Let the title be not only distinctive, but also brief. Then let the story be told in simple language, told as briefly as possible; "boil down," provided clearness and completeness are not sacrificed in condensation.

Of course the ordinary rules of syntax will be observed, and verbs and nouns will not be allowed to indulge in promiscuous intercourse. This may seem an unneeded direction, but it is often unheeded, for violations of it are not uncommon even in well-known writers.

Let strength be first sought rather than beauty. Richness of ornament and wealth of illustration must not be suffered to obscure thought or lead the reader away from the essential points; if these assist, make clearer and more attractive, and if spontaneous and incidental, like the rainbow that arches the waterfall telling the force of the rushing waters, very well. But let the writer never get on stilts and attempt to lift his head into the clouds. The subject and the style should correspond, and, as Voltaire has said, there is nothing more rare and difficult than to make this correspondence.

In a further consideration of the subject, we will speak more fully and plainly of the errors of composition as observed in professional writings, and of the means by which a good medical style may be acquired.

LECKY AND GRANT ALLEN ON PROSTITUTION.

Those who have read Lecky's "History of Morals in Europe" will recall his eloquent language in regard to the prostitute and prostitution, and his quasi-defence of this accursed form of social impurity.

This is the defence: In referring to the prostitute, he says: "Herself the supreme type of vice, she is ultimately the most efficient guardian of virtue. But for her, the unchallenged purity of countless happy homes would be polluted, and not a few who, in the pride of their untempted chastity, think of her with an indignant shudder, would have known the agony of remorse and despair."

Grant Allen, a name so well known in science and literature, in a little volume of poems recently published, entitled "*The Lower Slopes*," has one called "*Sunday-Night at Mabilles*," terrible and pathetic in its picture of the suffering and sacrifice of these miserable victims of man's lust.

The poem concludes with a question that probably may set those who are content to say that prostitution is a necessary evil, and that it protects the purity of countless happy homes to thinking at least:

"One question ever rises to my lips,
One question that I scarcely dare to breathe:—
If woman's virtue cost so much to keep,
Good friend, is woman's virtue worth the price?"

Antiseptic Snuff-Powder.

The following is a combination employed by Dr. Leonard A. Dessar:—

R	Menthol.....	10.0
	Tannic acid.....	2.0
	Boric acid.....	30.0
	Bismuth subnitrate.....	20.0
	Starch.....	50.0
	Cocaine.....	50.0
	Aristol.....	0.5

Sig.: Make a fine powder.—*International Journal of Surgery.*

YOUNG DOCTOR:—Just think! Six of my patients recovered this week.

OLD DOCTOR:—It's all your own fault, my boy; you spend too much time at the club.—*Life.*

ABSTRACTS.

URTICARIA: ITS NATURE AND TREATMENT.

By Dr. Stephen Mackenzie (*British Journal of Dermatology*. March, 1894).—As here pointed out, all the phenomena concerned in the development of an attack of urticaria can be easily followed out in cases of "factitious" urticaria, and in this way: A scratch at once brings out a white streak, due to contraction of the irritated cutaneous vessels, from stimulation probably of vaso-constrictor nerves; then we have a line of redness, wider than the original white streak, caused by vascular dilatation, quasi-paralytic in character; dilatation is succeeded by stasis, transudation of serous and corpuscular elements, this constituting the "wheal." There is usually but little diapedesis of colored corpuscles, hence the white or pink color of the wheal; but this may be more marked, or rupture may occur, hence *urticaria hæmorrhagica*; or the transudation may raise the stratum lucidum and stratum corneum of the epidermis, hence *urticaria bullosa*. The whole process is reflex, so that we must have efferent nerve fibres and a centre, the latter being probably constituted by "the dense plexus of fine nerve fibres in the superficial layer of the corium." This seems to be the mode of action of direct irritants; but what of *urticaria ab ingestis*? Dr. Mackenzie, while admitting that it may be a central reflex phenomenon starting from an irritation of the gastric mucous membrane, thinks it more probable that "something is absorbed which circulates in the blood, and reaches the nervous plexus in the skin," a view which the author finds supported by the facts that factitious urticaria is most easily provoked in cases in which the original cause of the disease is indirect, connected with some error of diet or some idiosyncrasy, and that urticaria is nearly always more or less widely and indiscriminately distributed over the cutaneous surface, and not in the territory of any definite nervous supply—entirely unlike the distribution of zoster.

The mucous membranes are sometimes affected in urticaria; that of the mouth may be seen to be swollen; there may be asthma or dyspnoea, from urticarial swelling in larynx or bronchioles; or hæmatemesis from an urticarial condition of the gas-

tric mucosa. On the skin, also, the urticarial papule may pass into an inflammatory papule, when we have the so-called *lichen urticatus*.

Dr. Mackenzie refers to some of the less common causes of urticaria, particularly to the association of the disease with hydatids; it sometimes follows pregnancy; in one case it occurred fifteen times in succession after the passing of a uterine sound; it may occur during menstruation or pregnancy, or from simple emotion.

After giving some details of a few very unusual cases, the author passes on to discuss treatment under two heads—removal of cause, and mitigation of effects. Local irritations must be removed—animal parasites, irritating clothing, unusual articles of diet. In acute cases very mild measures suffice—a simple and bland diet, a stomachic, and a warm bath. In more obstinate cases the skin must be soothed by a nightly warm bath (for fifteen minutes) containing starch or potassa sulphurata (2 ounces to 30 gallons of water), followed by a rubbing with a lotion of carbolic acid and glycerine, or smeared with a 2 per cent. salicylic vaseline. Ointments of carbolic acid and salicylic acid are often useful. Menthol is not of much service. In the severe form much good often results from swathing the affected parts with lint soaked in glycerine of lead (1 ounce to 20 of water). Internally the author has found the greatest benefit from antipyrine (20 or 30 grains at bed-time), which may be repeated each night in chronic cases. Salicylates, atropine, bromide of potassium (with or without atropine) are all recommended. In gouty cases, or when there is defective action of the kidneys with lessened excretion of urea, colchicum has been found valuable. Pilocarpine also is sometimes found to be useful.

Odorless Iodoform.

Iodoform, it is said, can have its disreputable odor successfully masked in the following combination: Iodoform, powdered benzoin, powdered cinchona, and magnesium carbonate, equal parts, and a little oil of eucalyptus. The formula is credited to Lucas-Championniere.—*Ex.*

SOCIETY REPORTS.

THE LOUISVILLE MEDICO-CHIRURGICAL SOCIETY.

March 9, 1894.

STENOGRAPHICALLY REPORTED BY C. C. MAPES.

MICROCEPHALUS.

DR. A. M. VANCE: This patient is three years of age, and my object in presenting the case is to make a continued report. It is a typical case of microcephalus. On the fifth of April last, I opened one side of the head, and on the sixteenth of the following June operated upon the other side. It has now been nearly a year since the first operation, and there has been practically no improvement in the child's condition. There was no unfavorable symptom following either operation; the child left the hospital each time on about the sixth day, and both wounds healed perfectly. One rather peculiar feature about this case is that the child has never been induced to partake of anything in the way of food except milk, and that is taken from a bottle. The mother reports that she has never been able to persuade the child to take any solid food.

As I stated at a previous meeting of this Society, I have come to the conclusion that craniectomy for microcephalus is an unjustifiable operation. This conclusion has been reached from my observations in the two cases upon which I have operated, and from reports of others who have done the operation.

DISCUSSION.

DR. C. SKINNER: What result was noticed from the operation?

DR. A. M. VANCE: At the time I performed the first operation upon this child, I felt quite encouraged, as there seemed to be an indication of improvement in intelligence, but now after nearly twelve months have elapsed, I fail to see any improvement whatever. Epileptic seizures still occur; they have been somewhat modified under the administration of bromides, but as soon as the bromides are withdrawn the attacks return.

DR. WILLIAM CHEATHAM: I looked at this child's eyes, and from the restlessness exhibited to-night, may be imagined the difficulty experienced in making an ophthalmoscopic examination; I was finally able to get a reasonably satisfactory view, and am satisfied that there is atrophy of both optic nerves. The mother states to-night that she thinks there is some vision. She bases this statement upon the fact that when the child is lying quietly on the bed, and she is moving about the room, the child seems to recognize her presence as she comes closer to it. I

doubt if there is any vision at all, as we know there are other means by which a child can recognize its mother's presence. The optic nerves are perfectly white.

TRAUMATIC ANEURISM.

DR. A. M. VANCE: At the annual meeting of this Society, last May, Dr. Turner Anderson exhibited a patient having traumatic aneurism of the femoral artery. I present the patient now to show the result of removal of the aneurism by dissection, and also show the specimen.

The history of the case is that the patient, about two and a half years ago, while working with a hammer and chisel upon a piece of steel, a piece of the hammer or steel flew off, penetrating his thigh. The bleeding was quite excessive, but he was seen soon afterward by his physician and the hemorrhage stopped by a compress. Subsequently the aneurism developed. On September 19th, 1893, I dissected out the aneurism carefully, and exhibit both the patient and the specimen. He has had a pretty rough time of it. Both the vein and artery were involved—aneurism of the femoral artery and a varix condition of the large vein in that situation—requiring a very careful dissection. I dissected the whole mass and applied a ligature above and below. On the twenty-third day after the operation he had secondary hemorrhage due to the fact that the femoral was double, commencing just above the aneurismal sac, and the ligature was applied so near the bifurcation that it was not permanent. There was no swelling of the foot on that side due to the ligation. It is evident in this case that collateral circulation had already been established. It was necessary to make a long incision to get sufficient space in which to work, and altogether the operation was a very difficult and tedious one. I believe complete dissection of the aneurismal sac is the best treatment of this condition, and the result in this case shows the wisdom of it.

DISCUSSION.

DR. A. M. GARTLEDGE: I agree that the probable cause of the secondary hemorrhage was that the ligature was applied so close to the bifurcation of the artery. This is evident from the fact that there was a little leakage on several occasions. I also agree that there is only one way to treat these aneurisms and that is to completely dissect out the sac.

Dr. T. L. McDermott read an essay on

APPENDICITIS FROM A MEDICAL STAND-
POINT.

(See page 813)

DISCUSSION

DR. A. M. VANCE: I agree with McDermott that appendicitis is one of the most interesting subjects before the medical and surgical world at the present time. The question arises in each case whether it is a case for the physician or surgeon, and I must say at the beginning that I think one of the greatest faults in the outcome of a great many of these cases is that the doctor does not call the surgeon sufficiently early. I have operated for appendicitis ten times and lost four patients. Of the four patients that died, two were the subjects of general peritonitis, and were practically moribund before the operation was performed. In one case the first symptoms had appeared about eighteen hours before; the other, about three days. I believe if both had been operated upon at the very onset, they would have been saved. Of the other two cases, one was in active sepsis at the time of the operation; Dr. Bailey and several of the other members present witnessed the operation. The man died from sepsis, without the paresis of the bowel that we nearly always see, because the bowels moved freely and there was no tympanites at any time. I believe firmly that unless a case of supposed appendicitis is practically well in twenty-four hours from the first symptom that attracts attention, an operation should be performed. It is my opinion that this will be the treatment hereafter. Surgical statistics are positive; while statistics from a medical standpoint are of no value whatever; because the ordinary medical man (without operation) cannot tell absolutely whether his patient had appendicitis or not. In proof of that fact, Richardson has gone over the death statistics of Boston, Cambridge, and various other cities in that section, and the facts show that the death rate in adult males from *peritonitis* in the last decade has been very great. What else in the young male can produce peritonitis except appendicitis, excluding traumatism? I am appointed to write a paper upon the "Determination for Operation in Appendicitis" for the next meeting of the State (Kentucky) Medical Society, and I believe the whole subject can be covered in one line—"Diagnosis; then Operation."

DR. WM. BAILEY: I do not feel that I can do the subject under discussion justice; in fact I do not know that I have any very thorough convictions about it. There is great difficulty in making the diagnosis of appendicitis. I am not sure about the many cases claimed as having been cured by the physi-

cian really having been appendicitis. There is great difficulty sometimes in differentiating appendicitis from what we used to call typhlitis and perityphlitis; those cases in which the appendix is not involved. I believe that a large number of them get well even under the care of the ordinary physician. But in cases of undoubted appendicitis I am doubtful of recovery without surgical procedure, and I think the greatest difficulty is in making that differential diagnosis. Great stress is laid upon the McBurney point, a prominence midway between the anterior superior spinous process of the ilium and the umbilicus. It is evident at first sight that this cannot avail because of displacement of the appendix. There cannot be a stated point of prominence, if, as has been proven by operations, the appendix is displaced, and I doubt if, the appendix being behind or external to the cæcum, there would be a point of prominence. There is, however, one important diagnostic point that occurs to me, and that is tension of the muscle on that side, even before a tumor can be recognized or there is any marked tenderness. I do not believe that we can recognize a tumor as soon as an operation ought to be performed. I do not think we ought necessarily to wait for a tumor. I think the impression made by perforation would be manifested by the impression made on the pulse. Now, in the case Dr. Vance speaks of, the heart was decidedly impressed; and, while the operation was well and quickly performed, I do not think recovery could have been possible under any circumstances. There was a large abscess, from which very offensive pus was removed, and the man was evidently under the influence of sepsis before the operation. He did not die from the operation or its effect. I doubt if he died as soon as he would have done if the operation had not been performed. The patient was sick only three days; the surgeon was called on Friday, operated on Saturday, and the boy died twenty-four hours afterward. The heart could not be maintained, the usual remedies made no impression upon it whatsoever. Of course we have all seen cases of so-called typhlitis, accumulations of fecal matter in the cæcum, etc., give rise to symptoms similar to those in appendicitis. The tumor may even be more marked than in an ordinary case of appendicitis, and I think the great difficulty is in the physician determining whether it is appendicitis or not. I would make it largely a question as to surgical interference, whether or not we can demonstrate that it is a case of appendicitis. I have seen a number of cases of so-called appendicitis—I regarded them as such—recover under medical treatment. In my observation of thirty or thirty-five years, in my own practice I have never had occasion to resort to surgical measures in the

treatment of so-called appendicitis, and have never had a case die. Perhaps they were simply cases involving the cæcum, yet local peritonitis developed in some cases. Frequently I have seen marked tumor in the appendicular region with constitutional impression, elevation of temperature, quickened pulse, tenderness on pressure and rigidity of the muscle, etc. Yet I do not know whether they were appendicitis or not.

DR. J. G. CECIL: I have no very pronounced opinion in regard to appendicitis because my individual experience in that direction is very limited. Like my friend, Prof. Bailey, I have never seen a case in my own practice that I can say positively was appendicitis. Those cases that I thought were appendicitis have recovered without operation. In the cases that I have seen, operation has not been indicated; the cases that I had every reason to believe were appendicitis have gotten well without it. However, I recognize the fact, which is established beyond any reasonable doubt, that many of these cases do necessarily require an operation to save them. Any opinion of a given case that I might have would, of course, be based upon the diagnosis of the case. My judgment as to operation would depend upon the diagnosis, and I am prepared to say if I were called to see a case of supposed appendicitis and could make out from the symptoms and history of the case that suppuration or perforation had occurred, I would not hesitate a moment in advising an operation. Until this feature could be substantiated I should be inclined to hesitate. I do not believe that every case of *supposed appendicitis* requires operation at once. It all depends upon the diagnosis. If a case of suppurative appendicitis is established beyond question, then an operation is demanded; but neither the surgeon nor the physician, to my mind, has yet given us a schedule of diagnostic points which will enable us to say one way or the other just what is the proper procedure. Notwithstanding the very pronounced and decided views taken by both sides, I am still "on the fence."

DR. J. L. HOWARD: I certainly think that appendicitis is a surgical disease so soon as the diagnosis is made, and should be operated upon without further delay. I have been unfortunate enough in the last year to have had two cases of appendicitis, one operated upon the other not. The first case was a young man whom several of the Fellows will doubtless remember. He was taken on Wednesday with pain in the right iliac region; there was no tumor, the pulse was not accelerated, and the temperature up to the time collapse came on, did not exceed 101° F. The next morning (Thursday) I made diagnosis of appendicitis; I did not pay any at-

tention to McBurney's point, because I do not see how we can expect to have any defined point in an organ as large as the cæcum, when it varies so much in shape from distension, etc. The diagnosis I made was catarrhal appendicitis, which I shall always regret because I think it is very misleading and we should not classify appendicitis as catarrhal. It does not matter what the nature of the inflammation in appendicitis is, it should be operated upon. I called in a surgeon immediately who agreed with me in the diagnosis, but as the patient had a pulse of 74 and was getting along so nicely, he advised waiting a day or two before operating. The case went on until Saturday night, when suddenly symptoms of general peritonitis set in, perforation evidently having taken place. Owing to the time of night I was unable to get a surgeon immediately, and operation was not performed until the next day. The patient was in collapse at the time. Right here is an important point: If I were a surgeon I would never operate upon a patient in collapse. The operation was quickly completed and the patient died a short time afterward. The other case had a similar history, and showed about the same condition. In both cases the appendix was almost entirely destroyed. In the last case it was very hard to find the appendix, only a small portion of it being left, and the cavity was filled with pus.

DR. TURNER ANDERSON: I have expressed myself so often upon this subject before this Society that I feel I have little to add to what I have already said on the question of appendicitis. I can talk only about my own experience, what I have seen, etc., and perhaps there will be little interest attached to it. I say now, as I have on a great many occasions, that the reports and specimens that have been presented at different times have not changed my views in regard to this trouble.

The first case of appendicitis I saw was in 1866, it was then called perityphlitis. That man is alive and well to-day. The name "appendicitis" was not known at that time, the nomenclature has been changed since. From that time to the present I will say that I have never seen a case not operated upon which terminated in abscess or in death. Within four months of the present time I saw a little girl ill with abdominal pain, having a tumor as large as a man's fist immediately beneath the McBurney point, that went on with dysenteric symptoms until it looked very much like a case in which an abscess had formed, and that operation would be nothing more than opening an abscess. Dr. W. O. Roberts saw the case with me. The child's pulse was good, inspection of the abdomen showed the tumor—it was not neces-

sary to palpate as it could be plainly seen. We concluded to wait until the next day, and the day following we waited again. There was a sudden subsidence of the pain and discomfort, the tumor entirely disappeared and the little girl made a perfect recovery. Her temperature on several occasions was 103° F.

Nine months ago I was asked to see a case with Dr. Roberts, a little Jewish child. The patient was lying in bed, with the leg flexed and all the evidences of perityphlitic abscess, tumor quite large. The mother strenuously objected to any operative procedure, and I told her that I believed the child would get well if let alone. I was not sent for in consultation at request of Dr. Roberts, but was asked by the people. I believed that the child would get well and would not force the operation. That child is running about now, going to school.

From 1866, when I saw my first case, up to the present time I have not seen a case that has terminated in suppuration, nor terminated in death, which was not operated upon. That is a queer personal experience. I do not mean to criticise the surgeons on the subject, nor their operative procedures; I simply state facts.

Some months ago I thought Dr. Cartledge had advanced views which were entitled to most important consideration. He suggested that the appendix was an organ which had some special way, when attacked with catarrhal inflammation, of getting rid of that inflammation by discharging into the cæcum—some special way which was not understood. I thought it might be possible for the appendix to fill up with a semi-liquid material and form a tumor without closing the proximal extremity of it. I thought there might be something in what Dr. Cartledge said, and the course he suggested might be pursued, which would explain recovery of some of the cases treated medically. I was much surprised at the last meeting of this society, when Dr. Cartledge, without prefacing anything he had previously said on the subject, exhibited a specimen of an appendix he had removed (the man having presented symptoms of recurrent appendicitis) calling attention to stenosis of the proximal extremity of it. I could not see anything the matter with it. I could not see anything abnormal about it simply from an ocular inspection. There had been no perforation of that specimen. So that my idea is that it was a case of catarrhal appendicitis, where the tumor had discharged into the cæcum, the accumulation having been gotten rid of in that way. Though Dr. Cartledge declared there was no such thing as "catarrhal appendicitis," he presented an appendix which, so far as I could see, had nothing the matter with it. It

shows how difficult it is for us to arrive at a satisfactory classification, or to intelligently discuss this subject from a pathological standpoint. Therefore, discussion of the subject from a clinical standpoint at the present time is the only standpoint from which we can get any special information. I believe if I were called upon to demonstrate whether an operation should be performed for appendicitis in an individual I had a great deal of interest in, I would decide in the negative. I have seen a great many cases of appendicitis; have been present at the operation; have seen the appendix removed and have not seen positive evidence of disease, nor evidence sufficient, in my judgment, to justify operation. And, as I say, I have not seen a case terminate fatally which was not subjected to operation.

There is one case to which I want to call attention without mentioning any names, where I think a man would have had better chances of life if he had not been operated upon. He was a beer drinker. Obese, flabby, had a weak heart, a depressed nervous system, and perhaps kidney trouble in addition. I think that man would have stood a much better chance to have gotten well if he had been let alone. He died soon after the operation, and so far as I am able to offer an opinion, there was nothing in the appendix that could have caused the symptoms under which he was laboring at time of the operation. I believe that operations for appendicitis are being performed too frequently; that there is entirely too much being done in this line. This thing of talking about recurrent attacks of appendicitis and operation to prevent the dangers that may come, I think is a grave mistake, and I believe it is a great deal better to trust to our old methods of treatment in these cases than it is to open the belly upon the slightest evidence of pain or distension. There are a great many people who suffer from constipation, indigestion, flatulency, etc., which might cause the same amount of pain and tenderness, and I believe that many mistakes are made when the belly is opened. It is a very difficult question, as the essayist has said, to determine what the condition is; I believe in a great many cases those conditions which were supposed to have been the cause of the disease are largely *post-mortem*.

DR. E. R. PALMER: I would like to ask Dr. Vance the final outcome of the case (Mr. W.) he operated upon some time ago for appendicitis?

DR. A. M. VANCE: The history of that case was that the man had suffered several attacks of severe pain, and everything pointed to appendicitis. At the operation, from a macroscopical examination of the appendix, I did not think it was diseased, but the microscope revealed that it was in a state of

active inflammation. The man has had a similar seizure since the operation, and there must, of course, be something outside of the appendix as a causative agent. He is a very nervous, hysterical man.

DR. A. M. CARTLEDGE: Did Dr. Anderson take the trouble to examine two other specimens I exhibited at the last meeting of this Society? He only mentions one. If he had examined the other specimens he would have observed a pathological condition certainly demanding operation. One was a large perforated appendix, and the other a necrotic stump of appendix with fecal matter pouring in the surrounding abscess.

DR. TURNER ANDERSON: I think those specimens were undergoing a form of resolution which may be common in tumor cases. Very recently I was asked to see a woman where I believe such a condition existed.

DR. A. M. VANCE: Did not Dr. Anderson see pus in the belly of a case of appendicitis upon which I operated in his presence some time ago?

DR. TURNER ANDERSON: I do not remember to have seen any pus; there may have been the remains of a hematocele, but I believe the appendix was in a healthy condition. I did not examine the specimen Dr. Cartledge presented with a great deal of care, but I could see no pus or anything else to indicate disease. I do not know whether rupture had occurred or not, or whether there had been an inflammatory exudate outside which had marked the effusion of pus. I asked him where the morbid evidences were, and he said I would have to take his statement that the appendix had contained liquid feces, etc. I told him that I would accept the fact that it was a case of appendicitis, and asked him to point out the point of stenosis which was supposed to be near the proximal extremity. He made the attempt, but I was unable to see anything wrong with it.

DR. J. L. HOWARD: How many cases has Dr. Anderson seen in which he has noted the formation of pus, or an abscess causing general peritonitis?

DR. TURNER ANDERSON: I have never seen a case terminating in suppuration or death.

DR. C. SKINNER: I do not know just where I do stand on this subject. It strikes me, though, that since the matter has been brought up, it has about resolved itself into a factional discussion. I am going to claim to belong to both sides. Some of you know that I sometimes do work in this line, and I also practice medicine. It would be a very hard matter to reconcile the statements made by the different speakers, but when we hear the statement from such men as Drs. Bailey and Anderson, who have been thirty-five and twenty-eight years respectively in active prac-

tice, that operation in the majority of these cases is not required, it would seem that their views are entitled to mature consideration. I am going to bore you with the recitation of two cases; one operated upon followed by recovery, the other not operated upon also got well.

The first case was a very thin woman, seen by me three years ago at the city hospital. She was about thirty years of age, and one peculiar feature was that she had no teeth. She was suffering at the time from what appeared to be an undoubted attack of appendicitis. She was carefully watched by both myself and the Internes. There was an exquisitely tender spot in the right side of the abdomen at about the McBurney point. In the first attack, under the application of cloths wrung from hot water to which had been added a little turpentine, all tenderness disappeared. I kept her under observation for two months, and in this time she had three attacks of this sort, and I pronounced the trouble fermentative indigestion. The woman, on account of the absence of teeth, was not able to masticate her food at all. As stated, diagnosis had previously been made of appendicitis. This woman became apparently well, but I left her in the ward at the expiration of my term of service. I did not operate upon her. My successor took this patient out of the hospital—some repairs were being made and it was deemed wise not to operate in the hospital—and removing her to one of the Infirmeries, operated for appendicitis. I was not present at the operation, and did not see the patient until several days afterward. From those who did see the operation I learned that the appendix was in a normal condition. Shortly after the operation and before the stitches were removed, she had another attack of the same character, and came very near dying. She finally recovered from the effects of the operation and went to Indiana. Last year, during my service at the City Hospital, this woman turned up again. She came into the ward and said that she had been having those attacks right along since the operation. I then secured for her a set of false teeth, and after several trials we succeeded in getting a set that would fit. Then arose the difficulty of getting her to properly masticate her food with the new teeth. I practiced the lavage treatment of the stomach, and up to the time I left the ward no more attacks had occurred. In about a month absolutely all evidence of trouble ceased.

No. 2.—In June I was called to see a young woman in this city who had always been the perfect picture of health, and another physician, her relative, had attended her for three days when I was called. She was taken ill very suddenly with intense pain in the right

iliac region. At the time I saw her she had been given a cathartic, the bowels had moved freely, but there was no cessation of pain. The pain increased and though the bowels were still open the temperature ran up, reaching 106° F., with a tumor in the right iliac region seemingly the size of two fists. I recognized the gravity of the case and called Dr. Bailey in consultation at once. I had already planned out a line of medical treatment—the use of opium and hot applications. This woman went along for two weeks under that treatment, making a good recovery, and

is well now. Here was a case of unmistakable appendicitis which recovered under full doses of opium, keeping the patient sleeping nearly all the time, and the use of hot applications, changing these every thirty minutes. The tumor disappeared and in two weeks she was up.

I hardly know where I stand on a question of this sort. I believe, though, where there are unmistakable signs of pus, or any evidences of perforation, that operation is justifiable.

[Continued in issue of June 16th.]

CINCINNATI OBSTETRICAL SOCIETY.

OFFICIAL REPORT.

Meeting of February 22, 1894.

Dr. E. G. Zinke exhibited the following specimens:

FIBRO-CYSTIC TUMOR OF THE UTERUS.

This specimen was removed from a patient who presented herself at the German Hospital a week ago last Tuesday, the 13th of this month:

Mrs.—, age forty-seven, very much emaciated, which made the presence of an abdominal tumor quite perceptible; mother of but one child, born twenty years ago. Never had a miscarriage. Has not felt well since the birth of the child. The first appearance of the tumor was noted some eighteen years ago, having grown steadily until it attained its present large size, filling up, as it did, the whole of the abdominal cavity. The tumor was fluctuant two inches above the symphysis, and absolutely solid below that point. The solid mass of the tumor filled out completely the pelvic cavity, so that the os externum could not be reached except by forcing the finger high up between the growth and the symphysis. The diagnosis was a fibro-cystic tumor, either of the uterus or ovary, or a fibroid tumor of the uterus complicated by a large ovarian cyst. The patient was very weak; her temperature ran up every afternoon to 101°; pulse 130, wiry and compressible. It was evident from her general condition that her days on earth were few if not relieved from this growth. Her physical condition was such that even operative interference promised

very little. However, the family, as well as the patient herself, embraced the only opportunity that was left. She was operated upon the 16th of this month. A free incision was made in the median line, probably seven to eight inches in length. A cyst universally adherent presented itself. The adhesions were very strong, firm and exceeding difficult of separation. The tumor was punctured with a trocar, with a view of emptying it and in this way facilitate removal. A large amount of chocolate-colored fluid escaped. After reducing the tumor in size, I found it impossible to separate the adhesions, and most of them had to be ligated and severed by the knife. After the tumor was freed anteriorly and from the omentum and intestines above, I attempted to get my hand behind the tumor to separate the adhesion. In this attempt I broke through the cyst, and its contents freely flooded all of the abdominal viscera. After a good deal of hard and persistent work I succeeded in eventrating the growth, but it proved absolutely impossible to liberate the solid portion from the pelvic cavity, and was obliged to fix this large and solid mass in the abdominal wound, abandoning the idea of liberating the tumor entirely. A clamp was put around it and the tumor transfixed. About twenty hypodermic injections of whiskey, as well as a transfusion of sterilized salt water solution, had to be made to keep the patient alive long enough to get her off the table. The following morning the temperature was 99°, the pulse 130.

She died of exhaustion forty-eight hours after the operation. The fluid removed from the cyst consisted of degenerated fat globules; no streptococci could be discovered. The tumor had its origin in the posterior wall of the uterus.

TOTAL VAGINAL HYSTERECTOMY OF A FIVE MONTHS' PREGNANT UTERUS FOR CARCINOMA COLLI.

The other specimen which I would present this evening is the contents of the uterus, removed after I had extirpated the uterus per vaginam. The patient was a woman, age thirty-nine, the mother of a large family, the youngest of which was only four years of age. The patient was referred to me by Dr. Koehler, of this city, who had made a diagnosis of epithelioma of the cervix. Upon examination I confirmed his diagnosis, and we determined to make a vaginal hysterectomy. There was some suspicion at the time that this woman was pregnant, but upon digital examination I could not feel the fundus of the uterus. She is a very large, heavy, fat woman, and I expressed it as my opinion that she was not pregnant, although I did not preclude the possibility of it. She had bled constantly, because of the cauliflower excrescences in the cervix. I operated a week ago last Saturday, at the German Hospital. After I had separated the cervix from its attachments I tried to pull the organ down. I could not feel the end of the uterus, and the organ was quite soft, and I recognized the fact that she was pregnant. Of course there was no use of hesitating any longer, and I had to put on the clamps and remove the whole pregnant uterus. I did not apply any ligatures. After we removed the organ we incised it and removed a four months fetus from it. The patient is now virtually well. She did not suffer from shock any more than a woman ordinarily does from an operation of this kind. It is highly probable that, had I known of the existence of pregnancy, we would not have operated upon this woman, and yet had we done so we would certainly have placed her life in great jeopardy, because the result would have been inevitable. Had this woman advanced to full term we would have been obliged to have made Cæsarean section, and the disease by that time would have made such inroads as to preclude the likelihood of a recovery. So, notwithstanding I did this without being in the possession of all the facts of the case, I have done the very best thing that could possibly have been done for her. She has not had an untoward symptom at any time.

The first specimen presented itself to me in this way: Had I been politic, or permitted policy to actuate my conduct in the case, I should have preferred to send her home with-

out an operation, but it appeared to me to be an act of cowardice not to make an attempt; for, although the appearances are unfavorable, it seemed to me to be my duty to present the case to her friends and leave it to them to refuse or accept.

The Electrical Treatment of Infantile Paralysis.

Dr. Lewis Jones, at the London Medical Society, March 5 (*The Lancet*, March 10th, 1893) read a paper on the above subject based upon an extended experience in the Electrical Department of St. Bartholomew's. His conclusions are that prolonged electrical treatment would do much good in nearly all cases, providing that the children were young and that not more than three years had elapsed since the incidence of the disease. He assumes that in many cases a considerable number of muscular fibres, damaged perhaps, but not destroyed, remain in the affected muscles, and that the motor or ganglion cells in the anterior horn of the spinal cord, which supply the muscles have a considerable vertical space and many of these might thus escape destruction. His purpose appears to be to bring the fibres which may happen to remain to the highest possible state of nutrition by applying treatment directly to them; if he expects to improve either directly or indirectly the cell in the cord he makes no suggestion of it. He divides the cases into two types.

The electrical treatment is to be applied twice a week, and the affected limbs bathed in warm water and well rubbed every night. Any form of electricity is of value which will stimulate living tissues, but if it has to be placed in the hands of the mother, faradism is best because most easily managed. Care should be taken not to frighten the child by sudden shocks. He summarizes as follows; 1. It is important in every case of infantile paralysis which has lasted for more than four weeks to try electrical treatment for six months or a year, if necessary. 2. It is exceptional for the muscles to be so completely destroyed as to have no functional fibres left. 3. A great development of these remaining fibres might be gained by a persevering stimulation of them by electricity. 4. When the electrical reaction is entirely absent or reduced to the lowest point some improvement may still be hoped for.

THE LIBRARY TABLE.

BOOK REVIEWS.

An American Text-book of the Diseases of Children, including special chapters on essential surgical subjects: diseases of the eye, ear, nose, and throat; diseases of the skin; and on the diet, hygiene, and general management of children. By American teachers. Edited by Louis Starr, M. D., assisted by Thomas S. Wescott, M. D. Published by W. B. Saunders, 1894.

The diseases of children, though a part of the study of general medicine, form a chapter in the healing art which is more or less distinct and separate from the rest of the subject. The symptoms, the cry, the cough, the expression of the face, all demand a special interpretation in babies which is not furnished by our knowledge of the diseases of adult life. For better understanding of the subject, therefore, we naturally look to the works of eminent authors; and since the tendency of the day is toward specialties, we rightfully expect from the pens of these specialists a terseness and exactness of statements which we can rely upon in any emergency.

The present volume is really an encyclopedia upon the diseases of children, embracing all that has proved valuable knowledge in the hands of no less than sixty-three American teachers, including the most eminent authorities on their respective subjects that the country has produced, among whom may be mentioned such names as Pepper, Ashurst, Da Costa, Gray, Hirst, Osler, White, Griffith, Deaver, and a host of other men holding prominent teaching positions in the leading medical colleges of America.

The work is edited in a masterly manner by Dr. Louis Starr, of Philadelphia, who has, in addition contributed chapters upon the discussion of "*Simple Atrophy*," "*Measles*," and the "*Clinical Investigation of Disease and the General Management of Children*."

Among the more strongly written chapters may be mentioned those of Osler's article upon tuberculosis, in which the most practical points are as to prophylaxis and treatment. The former consists in the destruction of the sputa and the disinfection of milk by boiling, when the source of the milk is of doubtful purity. The treatment he resolves into three essentials—sunshine and fresh air, nourishing food, and reconstructive tonics, such as cod liver oil, hypophosphites and creasote.

Starr's article on "*Measles*" is to the point, and at the same time written in an easy, agreeable style. The chapter on "*Simple Atrophy*" is condensed into five pages.

Among the other attractively written parts of the book may be mentioned the contributions of Ashurst on "*Appendicitis*" and "*Intussusception*," respectively. The nine chapters by Chas. K. Mills, especially those upon "*Headache*" and "*Insanity*," and of William White's "*Vesical Calculus*" and "*Gonorrhœa*."

The work is printed on excellent paper in large, clear type, and is profusely illustrated; and in every respect deserves a first place in the physician's library. W. H. H.

The Standard Dictionary.

The announcement is made of the completion of Volume 1, of the Funk & Wagner Standard Dictionary, and the statement is made that the second volume will be completed during the year 1894. An examination of the volume shows that it will meet the daily needs of the reader, perhaps better than any other dictionary in existence. It certainly will prove of invaluable service to all English students. It is the result of more than four years of constant labor by two hundred and forty-seven office editors and specialists, assisted by hundreds of other men and women. The estimated cost of the dictionary is over one million of dollars. The vocabulary is extraordinarily rich and full. The number of words and terms found in the Standard Dictionary is nearly three hundred thousand.

There are certain distinguishing characteristics of the work which greatly add to its value. For instance, in definitions of words, the most common meaning is given first; that is, preference is given to the order of usage, rather than the historical order generally followed in other dictionaries. The etymology is placed *after* the definition; a great convenience for ready reference. In the pronunciation of words, the scientific alphabet prepared and recommended by the American Philological Association is used. The quotations in the work, are located by book, page and edition from which the quotation has been taken. By a simple and comprehensive system, the best judgment of the English speaking world on all disputed points of pronunciation and spelling is clearly indicated to the reader. A systematic treatment of the compounding of words has been thoroughly undertaken. Obsolete, foreign, dialectic and slang words are given places only if likely to be sought for in a general English dictionary. Great care and labor has been bestowed upon every page and every article. Specialists in every department of science and learning have supplemented the learning of the editor-in-chief and his immediate associates.

A marked feature of the dictionary is found in the magnificent illustrations especially prepared for the work. For instance, under the heads of Architecture, Coins, Fowls,—fine illustrative plates have been prepared which greatly aid the reader, and are in themselves an education on the subject treated. Under the word decorations a handsome colored double plate shows the various decorations of honor used in the world. Under the title of Flag, the various flags of the world are exhibited, under the title of Gem,

a remarkable plate is given, showing the various colors and forms of the leading precious stones.

In technical and scientific matters, the Dictionary is far in advance of any other published. It is without doubt the best working dictionary that has yet appeared. Its scope appears to be almost unlimited, and

the work is as complete and reliable as possible. It is a great monument of exact scholarship; and it is not too great praise to say it is the best of English dictionaries. We unhesitatingly commend it to our readers as the Standard dictionary of the English language. It will be published in a single volume, as well as the two-volume edition. A. G. K.

CURRENT LITERATURE REVIEWED.

IN CHARGE OF ELLISTON J. MORRIS, M. D., AND SAMUEL M. WILSON, M. D.

THE ANNALS OF GYNÆCOLOGY AND PEDIATRY

for May. Dr. A. H. Buckmaster discusses

Hemorrhage after Abdominal Section: Its Place in Statistics.

The author is of the opinion that the reason that so little is heard of the deaths after abdominal section lies in the fact that men report only their successful cases and try, as much as possible, to make their results conform to the low rate of mortality that those expert in the operation have set. The author says, that since he has had the misfortune to lose a case from hemorrhage after operation, he has had over forty such cases narrated to him by almost as many operators. All of these cases are unpublished.

The author is further of the opinion that the drainage tube as a means of detection of hemorrhage has been overestimated, though in rare instances it may be of service. In support of this he quotes the experiments of Delbert both on dead subjects and dogs, in which it was found that it is almost impossible to keep the peritoneal cavity in communication with the open end of the tube, for if the intestines do not crowd into the end of the tube, it is soon sealed off by the exudate. The author is aware that this is not the general view of the profession, but, nevertheless, it has been borne out by his experience.

In studying the cases which he has been able to collect, the author has noted the following facts:

The greater number arose from the slipping out of the hypertrophied broad ligament from the grasp of the ligature. Next in importance to this cause was the reliance on pressure by means of sponges or gauze. Two cases were due to the slipping of a clamp after hysterectomy. A cause of hemorrhage to which the author claims to have first directed the attention of the profession, is occasioned by the use of the Trendelenberg position. In this position the flow of blood may not be noticed, because, with the hips elevated, the blood pressure in the pelvis is much reduced; but let the pressure be increased, by placing the patient in a horizontal position, and the hemorrhage may become free. But of all the cases given none are so fruitful in occasioning disaster as those which presented a broad stump that contained hypertrophied broad ligament.

From his own experience and that of others, the author has come to the following conclusions:

1. When the abdomen is closed after section the case is closed. No treatment short of that which is aggressively bad will influence the after-result. Nothing, therefore, should be left undone with the reservation that the case may require reopening. It is often better to run the risk of death from shock than the risk of death from hemorrhage. Many of the fatal cases were the result of that state of mind which the operator revealed when he said "I was afraid that the patient would die on the table, and therefore quickly terminated the operation by pressure on the bleeding-points by the gauze drain or sponges."

2. When symptoms of concealed hemorrhage are present it is too late to afford the patient more than a forlorn hope.

3. The use of the drainage-tube to indicate hemorrhage is not to be relied upon.

4. It is best, when possible, to enucleate all cases where the hypertrophied broad ligament forms a part of the pedicle.

5. In all cases of suspected hemorrhage the pelvis should not be elevated, for in this position the blood will gravitate out of the pelvis and collect under the diaphragm, where it is impossible to remove it without evagination. This blood will in many cases set up a peritonitis, and it is this peritonitis which it has been blamed for many deaths due primarily to hemorrhage.

6. That a patient may have no bleeding in the pelvis when she is in the Trendelenberg posture, because the arterial pressure is diminished; but when the pelvis is lowered, bleeding of a dangerous character may occur.

Dr. William Watkins Seymour reports

Three Successful Cholecystotomies for Gall-Stones,

with remarks based on six cases. The author feels that excision of the gall-bladder has no field save in gangrene or malignant disease, because its removal does not remove the laboratory in which the stones are formed. He also believes that the performing of the operation in two stages is a retrogression, markedly circumscribing our field of action in the cases with complications which are not to be foreseen and certain to result in incomplete and discrediting operations. The belly can by aseptic pads be thoroughly safeguarded

against bile, and the operation in two stages has no advantages which the simple operation does not possess many times over. The author prefers the incision parallel to the liver border to all others. This oblique incision gives the most perfect access to the gall-bladder and ducts of any incision that the author is acquainted with, at the same time admitting of perfect coaptation with a minimum danger of hernia.

Between cholecystotomy with suture of the viscous to the parietes and cholecystotomy with suture and dropping of the gall-bladder, leaving the peritoneum undrained, he believes the advantage to lie with the former. When the gall-bladder can be sutured well, he can see not only no objection, but an advantage, if the belly is safeguarded by temporary drainage and tamponade. If the stitches hold, the tube can be withdrawn in a few days at least, and convalescence materially shortened. In the cases where it is impossible to bring the gall-bladder into the wound, or where we are obliged, after failing in crushing or needling stones in the common duct, to excise them we can, according to the facility with which it can be done, either suture the opening, safeguarding it with drainage, or we may simply introduce a tube onto the opening and surround the tube with gauze till the belly is shut off. In cases where a fistula persists and proves detrimental to the patient's health, cholecystoenterostomy ought to be done, and the most rapid method seems to be with the Murphy's button. The use of the button, the author thinks, to sidetrack, without removing, stones obstructing the common duct is, in view of the irritative effects of gall-stones, an abuse of an instrument which promises much in its proper field.

The author is of the opinion that the time has come to regard gall-stones as a surgical affection; an affection which requires prompt intervention when the recurrences become at all frequent and severe. Neither Carlsbad water, nor olive oil, nor chloroform and turpentine can dissolve them when once formed, and to expose the patient to the many risks and unutterable tortures of many recurrences is downright wicked. Especially is this so when the mortality of the operations for this disease is extremely small.

Dr. Daniel Longaker, in a paper entitled

Two Symphysiotomies and an Induced Labor,

says, that his own personal decision would be not to employ symphysiotomy when the conjugate is below two and three-quarters inches (6.7 centimetres), but to regard the case as one demanding delivery by Cesarean section under the absolute indication. The author believes that it is preferable to have a vertex presentation after symphysiotomy. Forceps should not be applied until the head has passed through the os, and not until bladder, anterior vaginal wall, and cervix have been retracted. In every case the author has thus far seen these structures accompany the head in its descent to the pelvic floor. In one the forceps were applied early and the head could be seen passing through the os out-

side vulva. Manually we can supply the support which is lost through the spreading asunder of the divided pubic bones, thus there will be secured less disturbance of the anatomical relations of the post- and infra-pubic regions, earlier escape of the head through the os uteri, and less danger of laceration. Failure of foetal vitality would indicate speedy extraction of the child by forceps even before descent and escape of the head from the os uteri.

Dr. George M. Boyd discusses

Injuries to the Pelvic Floor and their Immediate Repair.

The author believes that the forceps is the cause of many tears of the pelvic floor. In his experience we have a new factor in the axis traction rods of the modern instrument as the cause of these injuries. He cautions that the operator should be mindful that while he is making traction in the axis of the pelvic canal he may also be producing, by pressure, serious damage to the pelvic floor. The author also discusses the question as to whether the use of the bichloride douche is objectionable on account of drying the secretions of the vagina, though he comes to no conclusion in the matter. He states that even if it should be proven that the douche did dry or remove the secretions, he would yet favor its use on account as a prophylaxis against gonorrhoeal, ophthalmia, and septic infection.

Perineal support has been of no service in his experience, except when extension of the head was favored by pulling the rectum forward. Direct pressure or guidance of the head presenting part in some cases seemed beneficial. In case of laceration of the perineum after labor, the injury should be immediately repaired under anesthesia, and with this end in view the author has frequently commenced the use of the anæsthetic on the first evidence of injury, with the result that when the third stage of labor was completed the patient was fully under its control, thus avoiding delay. The suturing of the rent should begin from within out, and the first skin suture should be placed much as the crown stitch in the Emmet operation. The author believes that Chinese silk is better for suture material than silkworm gut. After operation the patient should be kept rigidly quiet—catheterized every six or eight hours—given bichloride douche, 1 to 8000, daily. In the place of the ordinary vaginal iodoform suppositories, the author prefers the use of a pencil, 4 to 5 centimetres in length, made of iodoform grs. xxv, and sufficient starch and acacia to make the mass, when dry, hard, not easily broken. The advantage of the pencil over the suppository is, that while the suppository will dissolve within one hour and iodoform possibly escapes, the pencil will dissolve more slowly, requiring twelve hours. The pencil is also of advantage when it is desired to carry iodoform into the uterine cavity. The ordinary suppository melting or breaking to pieces in the grasp of fingers or forceps.

The author presents the following conclusions as the result of his experience:

First.—As every obstetrical case is greatly a mathematical problem, so is the safety of the pelvic floor; if the passenger is too large for the passage-way (something must give), a tear, either vaginal or perineal, will follow.

Second.—As it is our duty to study all obstetrical cases before labor by palpation and pelvinity, just as much is it our duty to examine the perineum and vagina after labor.

Third.—That having any injury of the pelvic floor, it should be at once repaired, and a good method to follow is to perform the operation under constant irrigation, using sterilized Chinese silk for sutures, and avoiding infection of the wound by placing the stitches without inserting the finger in the rectum.

Dr. J. A. Freeman contributes a paper on
Retroversic Uteri.

The only rational treatment, according to the author, is hysterorrhaphy, or ventral fixation; and he takes the stand that all cases of excessive retroversion should be subjected to this operation, which (according to him) is perfectly successful and safe when done under strict asepsis. The author further says that "Girls should be taught from early childhood to habitually lie upon the side, or, rather, sides alternately, and not in the supine position." The alternate sides should be used in order to produce symmetry of the body.

Dr. John G. Kerr, of Canton, China, concludes his interesting translation of

The Tat Shang Pin.

or midwifery made easy. The section on the regulation of the lying-in room is curiously like the same instructions one sees in modern books on the subject. The author states that when the period of confinement has come, two "of those steady, quiet, steady persons" must be selected to be in attendance. "There must not be too many, and it is better that they be relatives. They must with pleasant words request persons not to enter the room. In hot weather it is important not to have too many in the room, for the air becoming vitiated will be bad for the patient, and will cause giddiness, the evil effects of which will not be small. All persons in the room must walk lightly, speak gently, and must not indulge in much talking in order that the patient have quiet repose. It is of the utmost importance to exhort the patient to dismiss all fear, to be quite, to bear the pains, and not to be tossing about. Any remarks about strange and alarming things are especially to be forbidden, also whispering or sighing, for all these things cause her to be in doubt and troubled, and may result in evil.

"Everything in the room must be kept quiet, and in the patient's presence there must be no worshiping of the God, or making vows or invocation of heaven or earth.

"The midwife must enter the room alone, sit down quietly and not make confusion.

"A little food must be given to the patient frequently, such as chicken or duck, or the stomach and lights of hogs; but a little clear broth is better." Then follows certain rules for the determining of true from false labor-

pains with reports of cases from the author's practice illustrating his meaning. Another section is "On Nourishing the Womb" while "Diet and Drinks" are discussed further on. Abortion is also considered. In regard to the after-treatment, the patient is instructed to get on the bed and recline on a high pillow, but is not to sleep. Her knees are to be flexed and she must drink a cup of child's urine (though for what purpose we are not informed). The attendants are not to disturb her by loud talking.

The cause of retention of the placenta is said to be because the birth has been forcibly brought on too soon. "During labor the joints are forced apart. In strong persons they close up in a few days, but in weak persons a month is required. Now, if the delivery is forced before the joints naturally open, they will close up again suddenly, so that the after-birth cannot come away." This condition is not considered dangerous. "There is no occasion for fear, and it is unnecessary to take medicine. When the after-birth does not come away, tie a hemp threaded to a fold of the cord and attach a weight to it to keep it from going back. Then cut the cord off short. In from three to five days the placenta will shrink up and come away. The patient must be plainly told not to be alarmed and that she must not listen to the midwife who will want to take it away with the hand, which would be the cause of much damage." Insufficient milk is said to be caused by thinness of the blood and directions for remedying it are given.

[The "Tat Sin Shang Pin" is a popular work on midwifery, in common use among the people of China, and is the standard authority in all difficult cases, so Dr. Kerr states in his translation of the first part of this work which appeared in the *Annals of Gynecology* for March. Dr. Kerr has endeavored to give a literal translation of the work, the author of which he could not discover, though in all probability the work is several centuries old. Dr. Kerr is to be thanked for giving the profession this curious insight into the teaching of a people that we are accustomed to regard as barbarians. He has already, in a paper read before the College of Physicians of Philadelphia, some years ago, giving an interesting account of operative obstetrics among the Chinese, and we look with interest for whatever he may have further to say on the subject.—Ed.]

The remaining papers in this issue are descriptions of a number of specimens removed by abdominal section, by Dr. William Easton, and the discussion of "Fæcal Fistulæ," by Dr. Mordecai Price. In the "Department of Pediatrics" is a clinical lecture by Dr. J. P. Crozer Griffith.

Cholera Infantum.

R	Salicylate of bismuth.....	4.0.
	Prepared chalk.....	2.0.
	Tinct. canella.....	1.0.
	Peppermint-water.....	10.0.
	Malaga wine.....	10.0 to 30.0.
	Syrup acacia.....	100.0 to 120.0.
	Paregoric elixir.....	10 drops.

M. Sig.: A teaspoonful every hour.

PERISCOPE.

IN CHARGE OF WM. E. PARKE, A. M., M. D.

MEDICINE.

Typhoid Fever.

Dr. Jno. Elliot Woodbridge, of Youngstown, Ohio, claimed before the Mahoning County Medical Society that he has been able to abort all cases of typhoid fever coming under his care before the eighth day of the disease. He claimed that typhoid fever can invariably be cured when proper treatment is instituted at a sufficiently early period.

If the treatment (outlined in a very imperfect way by the doctor), merits the attention of the profession, we fear the dogmatic assertions of the writer will find, in time, a level much beneath their asserted value. Prescriptions Nos. 1, 2, and 3 are as below. The trend of the rationale of therapeutics set up in this "shot-gun" is that somewhere here is a specific antiseptic against a predicated typhoid germ:

No. 1.

R	Podophyllin.....	gr. i.
	Hydrarg. chlor. mitis.....	℥i.
	Guaiacol.....	℥vi.
	Thymol.....	℥v.
	Menthol.....	℥i.
	Sacch. alb.....	℥iii.

M. In very minute doses every half hour to one hour.

No. 2.

R	Potass. acet.....	℥i.
	Spir. nit. dulc.....	℥ss.
	Aque. dist. q. s. ad.....	℥iv.

Sig. One teaspoonful every half hour in water or lemonade.

No. 3.

R	Eucalyptol.....	℥ss.
	Spir. rect.....	℥i.
	Guaiacol.....	℥iii.
	Aque. dist. q. s. ad.....	℥iv.

Sig. One-half teaspoonful every three or four hours.

The only drug here with which we are not all familiar is guaiacol, a derivative of creasote. It is an anti-pyretic, even said to be such when applied to the skin. Da Costa very recently speaks of his experience with it:

"He finds that the reduction of fever, which in one case was from 105.4 degrees to 98.6 degrees, is not attended with marked change in the pulse, nor by cerebral disturbances. In the case mentioned, and a few others, a very great reduction was followed by a slight chill, but in one instance, in which the temperature was brought down to 97 degrees, there were present no effects upon the pulse, respiration or nervous system and no chill. The reduction of temperature was most striking in cases of typhoid fever. In pneumonia of a severe inflammatory type, the reduction was comparatively slight, except about the time of the crisis, when a natural reduction would occur.

"As compared with that of the cold bath, the effect of guaiacol is produced more slowly, but is decidedly more lasting. Thus in a case

of typhoid fever, the application had to be repeated but 16 times in 7 days.

"The proper dose to be employed will rarely be over thirty minims; excessive reduction of temperature followed the use of forty drops. It is to be painted or rubbed upon the skin which has first been prepared by washing with soap and water. It may be rubbed in slowly with the hand, taking five minutes for the purpose, and the surface then covered with lint or waxed paper. With a temperature of 103 degrees, it would be proper not to use more than twenty minims at the first trial.

"The chief objection to it thus far discovered, is its odor, which DaCosta has found to be best overcome by use of the oil of cloves.

"In private practice, the efficient use of the cold bath is often difficult or impossible, and it may be that here the external use of guaiacol will possess advantages that will give it a wide application."

Vomiting of Pregnancy.

When a physician has a very stubborn case of the above nature—a case that will not yielded to anything that he has tried—patient of a nervous and excitable temperament—cannot retain even a sip of tea or water—and fast growing into an alarming condition—please try the following promptly, and if the second dose fails to give relief, then I shall write no more; it has never failed in my hands, when ever other known remedy has:

R	Fld. ext. valerian.....	℥i.
	Fowler's sol. arsenic.....	℥xvj.
	Sodii bicarbonas.....	℥i.

M. Sig.—Teaspoonful every two or three hours.

The second dose usually relieves, and your patient will feel grateful indeed. Of course, all are familiar with these drugs, but the above combination is recent with me, and it has done what all known remedies have failed to do in my hands. Small doses of the valerian aggravate the nausea, while large ones quiet the whole system.—Julian Berry, M. D., in *Memphis Medical Monthly*.

Therapeutics of Phenacetine.

Dr. James T. Whittaker, Professor of Theory and Practice of Medicine, Medical College of Ohio, in his recent popular text-book on medicine, discussing the treatment of influenza, says: "The pain is best relieved by broken doses of Dover's powders, or in the presence of much nausea by phenacetine. Phenacetine may be given in a single dose of ten grains to secure a peaceful sleep." In measles he states that, "Any case of fever above 103° is best controlled by warm baths which may be gradually cooled, or by occasional administration of phenacetine, gr. iii-v, more especially in the relief of the

associated nervous symptoms." In scarlatina he prefers to reduce fever by cold, tepid or warm baths, or ablutions, but if as sometimes happens, it is necessary to resort to the use of antipyretics, he recommends phenacetine as the least injurious." It may be given to a child in a dose of five grains, to an adult in double this dose, once or twice in the course of a day. It is of especial value in headache or other nervous distress. It is best administered in capsule or in powder taken directly upon the tongue, stirred—that is, suspended—in milk, or in case of high fever with dry tongue, floated upon the surface of a teaspoon of water." While an adherent of the cold bath treatment in typhoid fever, Dr. Whitaker recognizes the fact that it is sometimes impracticable and impossible. Speaking of the use of chemical agents for reducing fever in this disease, he says that, "the safest of the modern antipyretics is phenacetine, which is best given in a large dose, three grains to a child, five grains in adolescence, ten grains to an adult, at the height of the temperature, which it will reduce in the course of fifteen or twenty minutes, a degree or two with some slight sweating, which in turn aids in sustaining the antipyresis." Dr. A. A. Stevens, in his "Manual of Therapeutics" recently published, sums up his experience with phenacetine as follows: "It may be used to lower temperature in diseases associated with higher fever, such as typhoid fever, scarlet fever, rheumatism and pneumonia. As an analgesic it is an extremely valuable remedy in neuralgia, headache, migraine, influenza, rheumatism and the crises of locomotor ataxia. It has been used with success as an antispasmodic in whooping cough."—*The Medical Fortnightly*.

The Reciprocal Relations of Mitral Stenosis and Pregnancy.

In the April issue of the *Univ. Med. Mag.*, Dr. Herman B. Allyn publishes a very profitable article with the above caption and relates ten very interesting cases of heart disease complicating pregnancy, or pregnancy complicating heart disease. The subject of the paper, he explains, is the reciprocal relations of mitral stenosis and pregnancy—that is to say, on the one hand, the effect of pregnancy upon the heart lesion, and, secondarily, upon the patient in general; and on the other hand, the effect which the heart lesion exerts upon the course of pregnancy and, secondarily, the effect upon the fetus.

This is brought out admirably by his reports of cases.

Coughs, dyspnoea and pulmonary congestion, with bronchitis are the most common symptoms of mitral stenosis in pregnancy. They appear after the fourth month and increase in intensity as pregnancy advances.

General oedema is not a common symptom. It occurs only in advanced stages of severe cases.

Albuminuria also is rare.

Convulsions or unconsciousness, occurred in six cases.

Cardiac pain, at times amounting to severe angina, occurred in six cases. Palsies apparently embolic in origin occurred in three cases.

His special point in the treatment is blood-letting, preferably by venesection. His indications for it are increase in the engorgement of the lungs or heart, or when constant orthopnoea, cyanosis, edema of the feet and legs, an irregular pulse and weak second pulmonary heart sound developes.

There is no doubt as to the great value of blood-letting in suitable cases. It relieves the engorged right heart, and by lessening the volume of blood upon which it must contract, permits of compensatory hypertrophy. The value of loss of blood is shown practically by the statistics already quoted—hemorrhage in some form occurring in 18 of the 37 favorable cases and in only eight of the fatal cases.

The puerperium should be closely watched and the patient prevented from rising or doing anything to cause overdistension of the dilated and weakened right auricle and ventricle.—*Fl. Wayne Med. Mag.*

Habitual Headache as a Prominent Symptom of Some Nasal Diseases.

Dr. Scheinmann makes the statement that most nasal diseases are accompanied by more or less headache, in many instances the headache becoming habitual. In both neurosthenic and hysterical persons, local examination of the nose should not be forgotten, as oftentimes the seat of the trouble is entirely within the nares. Headache is sometimes the only symptom of a diseased nose or accessory cavity, and by cure of the nasal disease the headache vanishes. In neurosthenic persons cocaineization of the diseased parts will oftentimes cause a disappearance of the headache. One of the most frequent causes of headache (from nasal disorder) is hypertrophic swelling of the turbinates, though the observations of the author prove that empyema of the antrum of Highmore, even combined with phlegmon of the orbit may be only indicated by headache. Cure of the empyema removes the headache. The author has found that carious gummatous processes, crests and spines of the nasal septum, and oftentimes lesions that seem quite unimportant, may be the cause of violent headaches, as proven by cases coming to his notice. He concludes by saying that in all cases of headache it is important that the nose should be thoroughly examined.—*Berliner Klin. Woch.*

Mucous Disease.

This is a very frequent disease of children, and is most common between 3 or 4 and 10 years of age. It consists of an increased secretion of mucous from the internal surface of the alimentary tract, which interferes mechanically with digestion and absorption of food, and by its influence in impeding nutrition, often excites suspicion of the existence of tubercle.

The symptoms are slight at first, and become more severe as the disease advances in

its course. The child is dull; disinclined to exercise, and complains of weariness. He becomes pale; loses flesh; his spirits are low; takes no pleasure in amusements, and is listless; sometimes crying without cause. He is drowsy during the day, and restless at night; his sleep often being disturbed by frightful dreams. Sometimes he arises from bed while asleep, and walks from room to room. Nocturnal incontinence of urine is frequently complained of. The appetite is capricious, and each meal is followed by flatulence and uneasiness. The appetite may remain good; sometimes the hunger cannot be satisfied.

The tongue is flabby and indented by the teeth, and has a glossy, shiny look, as if it had been brushed with mucilage.

The bowels are either constipated, or move frequently and scantily, and the stools contain large quantities of mucus.

The complexion is often jaundiced. The skin becomes rough and harsh.

The glands of the neck are liable to become enlarged on irritation.

The temperature of the body is seldom elevated above normal.

Worms form a frequent complication of this derangement.

Treatment.—Pay strict attention to the diet. Farinaceous foods must be forbidden, and the child nourished on meat, eggs and milk. Regulate the amount of food taken at each meal, and have them often.

At night bathe patient with hot water, and after drying rub in oil.—*Extract.*

Ice in Phlegmasia Alba Dolens.

Dr. John A. Miller (*Pacific Med. Journal*), in treating on the subject of "milk leg," speaks highly of the efficacy of the cold treatment of the disease. He first used it in 1886, and since then has used it in six cases with uniform and decided success. The procedure was in the following manner. An ordinary large towel was dipped into iced water, wrung out and clapped around the affected limb; a heavy flannel roller bandage was then applied from the toes upward to the groin. On the most painful parts, like the inner aspect of the thigh, the popliteal region and the calf of the leg, were laid rubber bags filled with ice. These were kept in place by a circular binder, independent and outside of the roller bandage. The patient was a little shocked when the cold towel was first applied, but the unpleasantness was only momentary, and then the reaction brought ease and comfort. She desired the ice bags to be renewed quite often at first, as she claimed they relieved the pain, as anything else had never done before. The pain was entirely controlled by the cold. The temperature dropped from 103° to 100° the next day, and the patient commenced to improve, which continued uninterruptedly. The towel was freshly dipped from four to six times in the twenty-four hours. As soon as the patient experienced relief, she was quite anxious to endure the temporary chill from a fresh compress, because the limb felt always better for

it afterward. The towels soon became dry and hot, and this gave rise to painful symptoms again.—*St. Louis Medical and Surgical Journal.*

Period of Infection.

The period of infectiousness of contagious diseases, according to the State Health Board of Pennsylvania is:

Small-pox.—Six weeks from the commencement of disease, if every scab has fallen off.

Chicken-pox.—Three weeks from the commencement of the disease, if every scab has fallen off.

Scarlet-fever.—Six weeks from the commencement of the disease, if the peeling has ceased and there is no sore nose.

Diphtheria.—Six weeks from the commencement of the disease, if sore throat and other signs of the disease have disappeared.

Measles.—Three weeks from the commencement of the disease, if all rash and cough has ceased.

Mumps.—Three weeks from the commencement of the disease, if all swelling has subsided.

Typhus.—Four weeks from the commencement of the disease, if strength is re-established.

Typhoid.—Six weeks from the commencement of the disease, if strength is re-established.

Whooping-cough.—Six weeks from the commencement of the disease, if all cough has ceased.

Under judicious treatment the period of infectiousness may be considerably shortened, but no child suffering as above should be admitted to any school after a shorter absence, and then should be provided with a medical certificate that he or she is not liable to communicate the disease.

Length of Quarantine.—Teachers or children who have been exposed to infection from any of the following diseases may safely be re-admitted to the school, if they remain in good health (and have taken proper means for disinfection) after the following periods of quarantine:

Diphtheria, 12 days; scarlet fever, 14 days; small-pox, 18 days; measles, 18 days; chicken-pox, 18 days; mumps, 24 days; whooping-cough, 21 days.

Adults may be re-admitted immediately, if they disinfect their clothes and persons.

Olive Oil and Chloroform for Gall-stones.

It is now generally understood that olive oil taken in large quantities is a useful remedy for facilitating the passage of gall-stones through the common duct into the intestine. Numerous cases have been reported in which this remedy has succeeded. In some cases, doubtless, the round, greenish colored masses which may be found in the stools of a patient who has taken considerable quantities of olive oil, may be mistaken for gallstones by one who is inexperienced in detecting these calculi; but a sufficient number of well-authenticated cases in which actual calculi have been observed, have been recorded to

give the remedy a standing sufficient to make it worthy of trial. The efficiency of the remedy may be greatly increased by simultaneously administering chloroform in medicinal doses. Opium is to be avoided in these cases, for while it relieves the pain, it at the same time increases constriction of the duct, whereas chloroform both relieves the pain and relaxes the involuntary muscular fibers of the duct, thus facilitating the passage of the calculi.—*Modern Medicine.*

Antiseptic Mouth-Wash.

In his "Treatise on Disease of the Mouth" E. Maurel gives the following formula:—

R	Alcohol of 85° degrees.....	3ij.
	Tincture of eucalyptus.....	5v.
	Tincture of cinnamon.....	3iiss.
	Tincture of rosemary.....	3i¼.

M. Sig.: A teaspoonful to a glass of warm water.

Treatment on Enteric Fever.

Maillart (*Rev. de. Med.*, November, 1873.) begins a study of cases of enteric fever treated by the internal administration of large quantities of water. The first object of treatment is to destroy the micro-organism, but failing this the action of their products must be neutralized. These toxalbumins are excreted by the kidneys. In enteric fever the urine is diminished in quantity, and the skin does not act, hence the object should be to encourage these emunctories. In order that a large quantity of water should be excreted, a large quantity must be provided. Subcutaneous infusion may be adopted if the patient is unconscious, or in severe hemorrhage. Water can also be supplied by rectal injections, but the simplest way is to make the patient drink copiously. The author endeavors to ascertain the effect of this treatment on the different symptoms in fourteen cases of enteric fever minutely studied. Only one case died. The patients take to this treatment readily. Exceptionally as much as 16 litres were taken in the day. The mouth became moist, and the trouble in swallowing owing to dryness of the pharynx disappeared. Thus antiseptics of the mouth is more easily effected. The stomach tolerates this treatment; in exceptional cases vomiting occurred at first, but this soon ceased. The water was excreted by the kidneys and skin, the quantity of urine being greatly increased.—*M. A. Practitioner.*

HYGIENE.

Water Purification by the Alum Method.

It has long been known that addition of small quantities of alum to impure water has the effect to cause the precipitation of its impurities, and this method has been used, sometimes on a large scale, as a means of purifying water. Max Teich, of the Institute of Hygiene of Vienna, has recently made a study of the value of this method, and finds that while the method offers no objection from a sanitary standpoint, and is capable of killing cholera germs, typhoid fever germs are not materially affected by it, and treatment of the water for at least twenty-four hours is necessary to destroy the germs of cholera.—*Modern Medicine.*

OBSTETRICS.

The Conduct of Ordinary Labor Through External Examination Solely.

Leopold and Sporlin (*Archiv f. Gynaekologie; Med. News*) make a warm plea for limiting examinations made in the course of ordinary labor to the external parts, and the advantages of such a course. Infection is thereby avoided; the natural sense of modesty of the parturient is not offended; and careless rupture of the membranes is avoided. Skill in external examination is acquired with reasonable readiness. In the large majority of cases such examination alone is sufficient for the recognition of the position and presentation of the fetus, and for the study of the course of an ordinary labor. As there can be no objection to its frequent exercise, abnormalities of parturition may the more readily be detected early, and means of correction promptly employed. Experience soon teaches the difference in the position of the fetus assumed in case of pelvic contraction on the part of the mother. The position and presentation having been recognized by external examination for the determination of possible pathologic conditions of the birth-canal need be but brief, and can be conducted with great care. For the attainment of this desirable result it is essential that the obstetric pupil familiarize himself thoroughly with the conditions of normal labor as determined by physical external examination, as well as with the physiology of normal labor. Obstetric operations are principally to be taught upon the phantom.